the Canadian Nurse

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MENTAL HEALTH
AND
PSYCHIATRIC NURSING

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Between Ourselves

Those of us who were active in nursing during World War II were familiar with the term "priorities." Literally, it gave precedence to affairs that were of immediate and primary importance, subordinating all less urgent matters to their proper level. Today, no less than in the early forties, there is occasion to again stress the importance of priorities in our professional life. There is a seething unrest in many areas of our association activity, both nationally and provincially. As guest editor, KATHERINE MACLAGGAN, second vice-president of the Canadian Nurses' Association surveys some of the problems that confront us nationally. As our observer and reporter, VIRGINIA LINDABURY writes of some of the problems that bubbled to the surface during the RN AO conference for staff nurses held in Toronto.

This *Journal*, as the chronicler of the current history of nursing in Canada, has a very real responsibility to keep not only the active membership of our association informed on what is happening but also to serve as the medium of information for the many thousands of women who have once been members with us, though now inactive. Because the price of the subscription to this *Journal* is included in the active membership fees of every active member, they have a continuous opportunity to keep abreast of all of the developments reported. In a few of the provincial associations, the fee for associate membership also includes the subscription price. But what of the vast number of inactive nurses whose chief source of information respecting present-day nursing is confined to items they may read in their newspapers?

The nurses of Canada will move forward with confidence and in strong support of developing projects to the extent that they know and comprehend the realities. Inversely, they will gradually lose faith in themselves and their associations, they will wallow in suspicion and frustration, if they do not understand those same realities. What are the burning realities nursing is facing today? Miss MacLaggan focuses attention on some of them, Miss Lindabury on others. To the individual nurse, perhaps the most clearly delineated reality is the salary she receives, compared with the pay of other workers in the same organization.

Our history will be what *we* make it. If we cannot accept time-honored answers to our problems, *we* must seek and find new solutions. *We* means all of us.

* * *

Until a former mental patient wrote a book entitled "The Mind that Found Itself" early in this century, very few institutions provided anything but custodial care for those who were mentally ill. Today, an exceedingly active body, the Canadian Mental Health Association, shares information on treatment and cure from coast to coast. A special committee of that association prepared a lengthy report on the present situation which is available to all in book form. "More for the Mind" has been quoted freely by Dr. C. A. ROBERTS, a member of that committee, in his article "Whither?" Should you wish to procure your own copy of this book, after reading Dr. Robert's article, it may be purchased from the Canadian Mental Health Association.

An excellent film entitled "The Psychiatric Nurse" is available free of charge from: The Medical Film Centre, Smith, Kline & French Co., 300 Laurentian Blvd. Montreal 9, Quebec.

* * *

SIX RULES FOR LIFE

1. Eat and drink in moderation for your health's sake.
2. Read only the best writings for your mind's sake.
3. Study politics (and watch the politicians) for your children's sake.
4. Read the whole Bible (at least once) for your soul's sake.
5. Be honest and sincere for your honor's sake.
6. Pick the right man for your husband, for heaven's sake!

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Administration—One or two tab. (or tsp.) q.4.h.

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Random Comments

Dear Editor:

In 1962, I left Canada as a nurse-missionary for Japan for a one-year period. It was with keen anticipation and eager enthusiasm that I arrived in Okayama (the "Okanagan" of Japan, in my opinion).

The hospital here consists of two separate buildings, with the older one located in the heart of the slums and the newer one just beyond this area. Seen through Western eyes, the hospital would appear to be in a deplorable state. Though the actual facilities may be lacking, however, they are more than compensated for by the service given.

My job was to work in the operating room four and a half days each week while allocating one day for home visits. Invariably, requests for instruction in English conversation came flooding in from the first day that I arrived. Since I had no qualifications along the lines of Christian education, my only contribution towards Christian witness was through my daily contacts at work as well as in the dormitory where I stayed.

My reasons for writing this letter are twofold: First, I would like to remind those of you who are Christians that each of us has a missionary responsibility wherever we may be. Before embarking on this journey the word "missionary" evoked images of elderly ladies dressed in grey in keeping with their pious natures. It was a pleasant surprise to discover that missionaries are not only very "human," but have very stimulating and often controversial types of personality. The variety includes not only diversity in personalities, but also in ages — from the early twenties to retirement age.

I have stated that my contribution as a Christian was through my daily contacts. What I have gained spiritually in Japan, has been so great and has made such an impact on my previously stagnant spiritual life, that I find it difficult to understand why I was ever satisfied to remain in such torpid waters. Having become conditioned to such an environment. I rarely attended a Nurses' Christian Fellowship gathering during my training. "That's for those oh-so-

good church-going kids", was my reaction. Thus, it was with shame and sorrow that I found I could not be more effective in my attempts to organize a strong N. C .F. movement here in Okayama. "So what?" may be the reaction of many readers. This leads to my second reason for writing.

Living in a "Christian" country, one isn't considered an oddity in professing one's faith. Here, in Japan, a person is not only an oddity, but is expected to be a paragon of virtue. For a *nurse* to accept Christianity is doubly difficult. The great burden to the modern nurse in Japan is her low status in Japanese society. There is a difference between an *A* and a *B* nurse which would be equivalent to the difference between our registered nurse and the nursing assistant. The *B* nurse in Japan undergoes a two-year training period after completing junior high school (grade 9), but here the similarity to the nursing assistant ends. It is not uncommon to find smaller hospitals almost completely staffed with *B* nurses. They do the work and take the responsibility of a registered nurse.

It is not my intention to compare the two nor to discuss the technical aspects of the training of either. Because of the general low status of the nurse, there is *almost* no feeling of pride associated with the fact of being a nurse. There is only indifference, at best and shame, at worst. This is accentuated in the case of the *B* nurse since she has not completed senior high school. In a country where suicide is not uncommon when the latter cannot be achieved, it becomes an evil cancer of inferiority, manifesting itself in many ways. Girls avoid hospital topics in their conversation in public. They may even go so far as to avoid former patients in order to spare themselves the public humiliation of having it known that they are nurses. Unbelievable? Granted, this is the extreme, but it does occur.

Added to this are factors such as doctors being considered demigods; consequently, the nurse often acts as a personal maid. Then too, one must remember that Japan is a male-dominated society. The Nurses' Association of Japan is working very hard to raise the status, the standards and the salary of its nurses.

These are the conditions under which a nurse labors in this country — a country that is said to be the most progressive in Asia. If this attempt at writing evokes a feeling of gratitude, to those nurses who

have blazed the trail before us; of thanks to those who have elevated our profession to the noble calling that it is; of humility, in realizing how small an offering our service is in the light of God's love for us; of understanding and encouragement for those nurses in other lands, struggling to gain recognition, then my purpose has been accomplished.

ROSE IMAI, Okayama Hakuai Kai,
37 Hanabatake, Okayama Shi,
Okayama Ken, Japan.

Dear Editor:

I do not know when I have appreciated any article more than the one on "Basic Qualities of a Good Nurse" by Ruby Rogers and Wilma Ballantyne (October 1963). It struck a very responsive note in me, and it was gratifying to find others writing an article based on the kind of philosophy which we have been trying to instil and perpetuate in our school and nursing service.

If there are reprints available, I should very much like to have several, and will gladly pay any charge there may be.

ELLEN D. HOWLAND,
Director of Nursing,
New England Deaconess Hospital,
Boston, Mass.

Dear Editor:

I have just finished reading the long-awaited article "Collective Bargaining and the Professional." I must say it left me discouraged about the future of the nursing profession — in Ontario at least.

I wonder how Dr. Cripso knows that "For most of your members this (a withdrawal of services) does not seem to provide a vital alternative." Has an over-all vote of the membership ever revealed how many of us would like to use this one workable weapon? It seems to me that every nurse I have ever talked to would be excited about using this method of improving her working conditions, wages, etc.

Is it not those at the top, those nurses who draw good salaries, who cry "non-professional!" to the use of the strike? (I notice Dr. Crispo does not even use this *naughty* word). Well someone is objecting and staff nurses who work the hardest are the ones who suffer the most.

Dr. Crispo finishes his article sounding as if he almost pities us. He leaves us with "the challenge" and in our "unenviable

position." He asks us to "trust the 'invisible hand'." How much have the forces of supply and demand done for us lately? There is apparently a desperate shortage of nurses. Not desperate enough, it seems, to do the one thing that will bring us all back to the profession in a hurry — more pay.

Those are my thoughts concerning Dr. Crispo's message. In the meantime, I will carry on for 8 1/2 hours at a job I just love. knowing all the while that my husband (also a professional) earns 25% more than I do in just *one hour!*

(Mrs.) MARION A. ANDERSON, Ont.

Dear Editor:

Thank you very much for returning the author's biographical data to the first page of the article concerned. Perhaps it is "all in my mind," but it does facilitate smooth reading which naturally increases my enjoyment of the *Journal*.

It was disturbing to read in the August issue that Dr. Badgley feels that "in recent decades nursing has not been characterized by strong leadership." In that very issue I thought I heard the voice of a leader when I read "Our Dilemma has More Than Two Horns" by Miss Hazel Keeler. In the July 1963 issue I heard the voice of another nursing leader when Mrs. Blanche Duncanson asked us "Who Speaks for Nurses and Nursing?" In the October issue, several voices can be heard if one reads the articles by Miss Linda Long and by Miss Rogers and Miss Ballantyne.

These are only a few of the women who are giving strong leadership to Canadian nursing today. Lest they become discouraged by remarks such as Dr. Badgley's, it would be nice if they could know that the rank and file of nurses recognize them and appreciate their work.

(Mrs.) GLORIA KAY, Ont.

* * *

STUDENT EXAM BONERS

An atheist is one who gives ether in the O. R.

The first president of the CNA was Fabiola.

An example of a ball-and-socket joint is the eyeball.

Phlebitis is an inflamed phlebite.

Dear Editor:

Are the entrance requirements for nursing too high? In a large percentage of cases, the answer to this question is *yes*. Many girls who wish to become nurses are rejected. Why?

One reason, I believe, is that the required marks are too high. Why should a girl be turned away because she lacked a mark or two in geometry or algebra when she wrote her matriculation papers? She doesn't need to know A+B=C or Theorem 5 in order to give a hypodermic injection or to assist in the operating room.

There is talk that a year or two of college will be needed prior to training. This is an added expense and many parents are unable to finance such an education. It is another deterrent for those wishing to enter a school of nursing.

In the past, the definition of a student nurse was "One who has entered a training school for the purpose of acquiring a knowledge of the moral, practical and scientific care of the sick. She shall bring, as her contribution to the training, youth, health, enthusiasm, education, sympathy, a good reasoning power and, above all, a conscience." What more could anyone ask in a nurse?

Let us look at these qualities. All students are healthy and young and have a high school education. Not all, however, have enthusiasm, and sympathy. Some do not appear to have a conscience. However, many students who lack these qualities do make excellent marks. Theoretically, they have the necessary requirements; personality-wise, they do not.

How can we eliminate this condition? One suggestion is to accept all high school graduates who desire to become nurses on a "trial basis." Watch their progress closely and, at the end of a given time, disqualify those not suited. This way only the best would be left. It would also "weed out" those who entered training to please some friend or relative.

Speaking as a supervisor and former patient, I say, give me every time the girl who has thoroughly absorbed her learning to the extent that she knows *how* as well as *why* to do a certain procedure. These girls are the best nurses.

I may sound as if I'm against education. I'm not. To grow mentally we need to continue learning. In nursing we need to be able to apply our knowledge to practice. By keeping those with high ideals and a willingness to learn we will raise our standards morally, as well as theoretically.

(Mrs.) RUTH CLARK, Nova Scotia

Dear Editor:

Three parcels of nurse's texts have already arrived from Canada (see Random Comments, Dec. 1963). On our last trip to Kano, my husband took them into the City Hospital Training Centre.

The director of the school was delighted! "It will take me a little while to get over this," he said. "This is a *real library!*" Then he showed my husband about four or five books which had previously formed the school's entire reference library. He stated that the additional books will make a great difference to his course and will affect the level of work that he can expect from the students.

Thank you very much for your generous help.

Rose Hutchens,
Kano, N. Nigeria

¶ *You too can help. Send nursing texts to:* "Books from Canada," P.M.B. 3077, Kano, N. Nigeria. *Bound books can be mailed in a maximum weight parcel of 11 pounds for 89 cents.* Ed.

Dear Editor:

When I took a postgraduate course in ophthalmic nursing at a well-known hospital in the U.S.A., I found that unqualified Canadian nurses were in charge.

Experience as advertised was not given. Questions on the examination paper covered subjects that had not been discussed in class.

I then worked at the Eye, Ear, Nose and Throat Hospital in New York and it was here that I received the best experience in both theory and practice.

A. Gontero, Ont.

Dear Editor:

I recently applied for a postgraduate course in neurology and neurosurgery at The National Hospital, Queen Square, London, England (as advertised in the *Journal*).

My application was rejected since applicants over 30 years of age are not eligible for admission. I would like to know why this requirement is not listed in their advertisement.

R. J., Alta.

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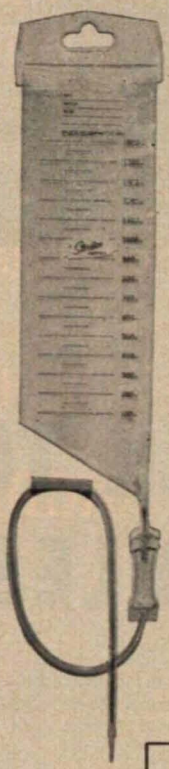

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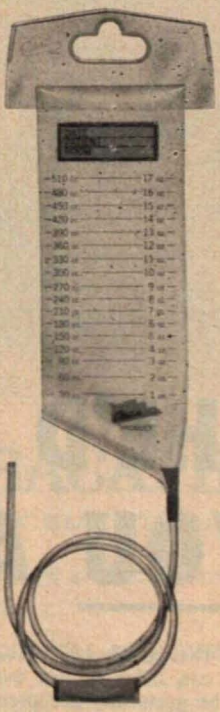

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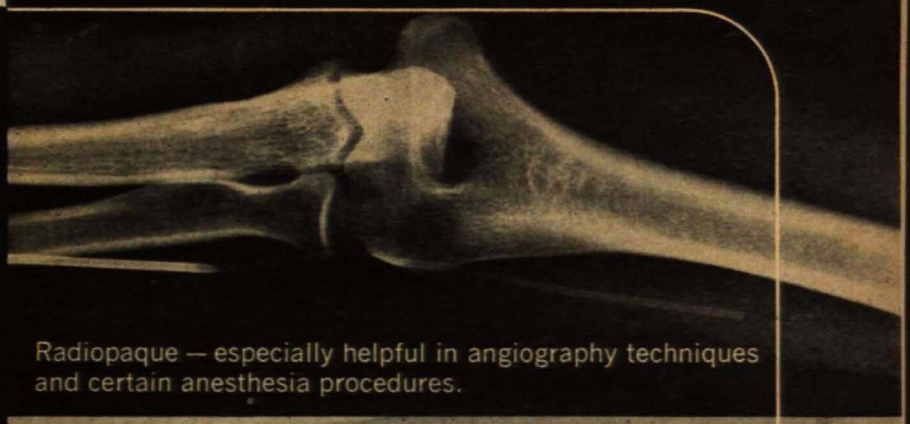

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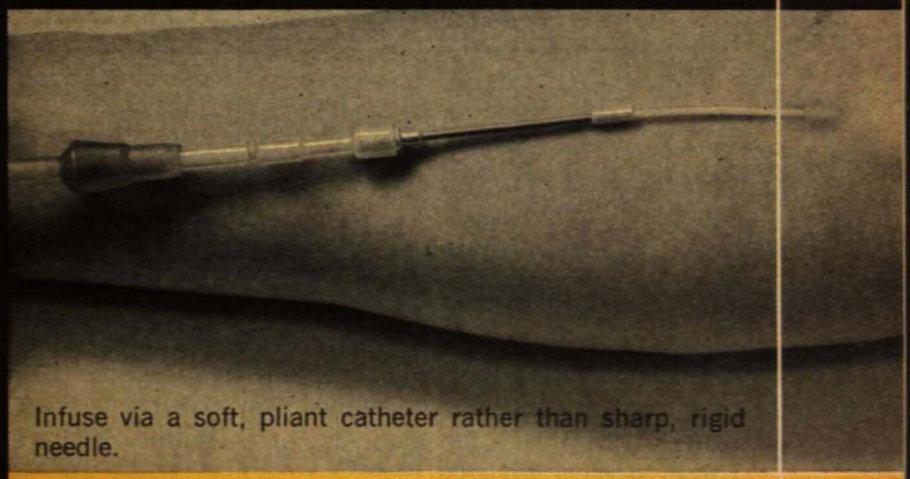

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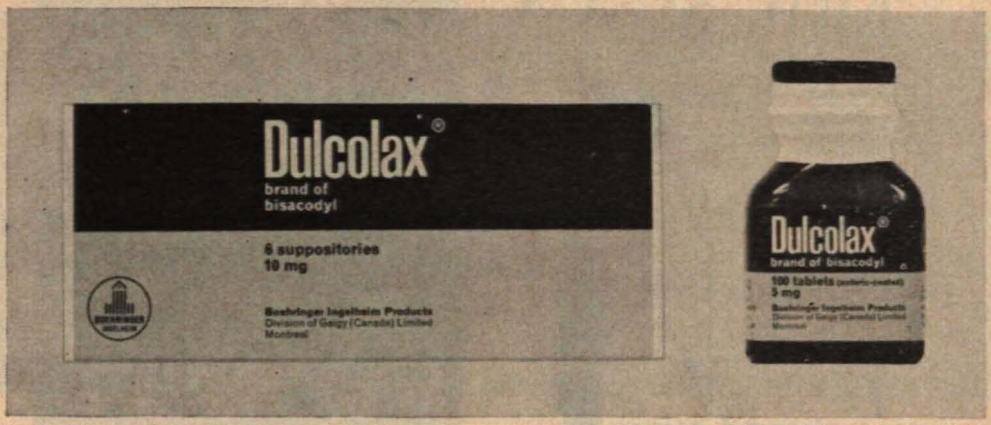

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VENUS PERALTA, FILIPINA, AGE 4. One of five children. Father dead. Mother earns about 50¢ a day. Sells fish in market. Live in one-room shack in squatter area. Roof rusty galvanized tin salvaged from cans. Walls scraps of firewood. Cooking and washing done in lean-to. Children ragged. Main food source sweet potato patch. Privation acute. Mother sickened with despair for children. Help to Venus means help to whole family.

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PLAN is a non-political, non-profit, non-sectarian, government approved independent relief organization. Financial statements are filed with the Montreal Department of Social Welfare *and are available on request because we are proud of the handling of our funds.* PLAN helps children in Greece, Italy, South Korea, Vietnam, Hong Kong, the Philippines, Colombia, and Ecuador.

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AUTHOR OF THE FUTURE

or

GHOST WRITER OF THE PAST?

Almost without being aware of the process, nursing in the sociological sense, in fact, in any sense, has become big business. Its bigness, importance, significance, call it what you will, must be reflected in all aspects of activity in the Canadian Nurses' Association. Only a mature and powerful organization has the stuff of influence, able to relate to an unknown future as if it were a familiar friend. A weak and fumbling organization can aspire, at best, to being the archivist of the past. Which shall we be, the authors of our future or the ghost writers of our past?

Assuming that all our professional staff, officers, committee chairmen and members are the epitome of efficiency and intelligence, a slow-moving and cumbersome structure can make them appear to be inept and unknowledgeable. Is CNA, with its machinery of the 1950's, capable of handling the future without reference to change from within? If not, let us invent a structure which is capable of a head-on encounter with the future.

CNA has some responsibilities to discharge, both to its members and to society. By the same token, its members and society have a responsibility to CNA. There is a circularity here that is inescapable, pointing up the fact that an organization takes on an identity which is both separate from and part of its membership, and separate from and part of society. More than anything else at the moment, we need the structure that will facilitate the meeting of our responsibilities.

For example, CNA needs to move quickly to improve the economic status of its members. True, our provincial associations bear the brunt of this area of concern, but there is some evidence to support the conclusion

that no one has been extravagantly successful. Lest anyone think that the salary of the nurse is an unworthy object of a national organization, let me quote an authority[1] on the subject:

"Perhaps I need scarcely add that nurses must be paid the market price for their labour, like any other workers; and that this is yearly rising." (This was written in 1867!)

To nurse is to nurture, to comfort, to cure, and to control and administer the nursing environment. By a strange anomaly in the economics of health, our salaries advance in ratio to the distance away from patient care. The money lies in administration, yet the life blood of nursing lies in direct patient care. Our best practitioners belong here, and the best of anything should always be a precious commodity and should be paid for accordingly. If we really believe in quality service to the patient, and if Canadians decide that they truly want quality service, let us see to it that both the money and the prestige move in the right direction.

Then there is the question of numbers of nurses and the classification of nurses based on educational background, to say nothing of the classification based on role. Had we the courage, we could devise the means to resolve the dilemmas and the confusion of who does what in nursing. CNA has the classical leadership role here.

Maybe the nation, in the spirit of its centennial celebrations, will grant us the educational opportunity needed to equate to society's demand for our services. In the same spirit, an income correlated to our value to a grateful nation would be quite in order. Difficult things often take a hundred years to achieve, but a properly structured CNA might accomplish it. There are three and a half years left in Canada's first century in which to try.

Sometimes we forget that the mammoth hospital system in our culture is largely a phenomenon of the past six years. Any sense of failure which we may have about keeping pace with expanding demands for our services is inconspicuous when compared to society's failure to provide a system of education which will create the type and number of nurses needed. Self-criticism is good for the soul when it results in positive action. By the same thought process, our criticism of others levelled at the proper time and in the proper way can be good if it results in positive action. We get nowhere if we can't define our problems. And we must be able to recognize our failures. Equally it is a duty to point out when and in what ways we have failed. CNA can and should do this, for the good of its members, but also for the good of society.

Nursing service administration often leaves much to be desired, but to continue to belabor the nursing role without reference to the power group at the hospital management level is to invite defeat. You cannot always put your own house in order in a climate of disorder over which you have no control. By a strange anomaly of our culture, nursing has not yet fulfilled its destined role of partnership in top-level administration. Until it does, our problems here will be chronic. CNA must expedite the fulfillment of this partnership.

The present lack of clarity in purpose, in definitive roles, in organization of new professionals in the health services does not make it easy for nurses, or doctors either for that matter, to chart their new relationships. Neither does it permit holding to relationships of the immediate or distant past. If we need new professionals, technicians, and semi-skilled workers in the health services, those who have been there longest have a duty to assist the newcomers to find their most effective role. But this role must never be permitted to be at the expense of professionalism in nursing. Blueprinting and safeguarding our professional role is the ongoing responsibility of CNA.

As a corollary to this responsibility to define our roles, our institutions of higher education must take

[1] A Bio-Bibliography of Florence Nightingale, compiled by the late W. J. Bishop, F.L.A., completed by Sue Goldie, B.A. Oxon. Dawsons of Pall Mall, London, 1962, p. 30.

note and qualify us for our tasks. Ineptitude and ignorance abound among the under-educated. Skill and knowledge prosper among the educated. We have a right to prosper, but only in the coin of the educated mind. It is ridiculous to claim a peer relationship with professional people in the absence of equivalent skill and knowledge. It is equally ridiculous to negate a peer relationship when such has been earned and is needed.

Self-government and self-direction are tough assignments — so tough that many people prefer to escape this form of freedom. For CNA there can be no escape. Whatever issues move into the horizon must be coped with as if they were welcome. What is truly an issue does not remain static. Either it is faced and resolved or it glides into other hands for treatment.

This brings me back again to the structure of CNA. The modern world has spawned great, big corporate institutions, and our organization must match, on a peer relationship, all the corporate institutions which impinge on our role. Such a relationship is constant. This means, in effect, that leadership is a full-time job. We can begin, then, to think in terms of an able and large secretariat in national office, where the jobs are the most demanding and rewarding of all the nursing positions in the land. Such an arrangement would not negate the benefits which the mobility of elected leadership brings. It must, however, mean that the key people in secretariat positions wear the mantle of leadership in the public domain.

Let us move with our ideas, our support, our money, our human resources, to create a Canadian Nurses' Association in the modern image. This is the way to write our contract with the future.

KATHERINE MACLAGGAN,
2nd Vice-President,
Canadian Nurses' Association.

WHITHER?

C. A. ROBERTS, M.D.

Changing patterns and evolving roles in mental health services.

One of the great social problems of our day is the treatment of patients with psychiatric disabilities. If we are to contribute to a reduction of this problem, it will be necessary to consider our approach to treatment.

Historically, we have denied to those born with less than average abilities and skills, to those suffering from permanent disabilities and to those who have a long-term disabling illness — particularly the mentally ill — the opportunity to equip and train themselves for effective living. Because of various stigma developed by society, we have withheld from them the right to live effectively even when they are trained and equipped to make an effective contribution.

Society has placed great emphasis on the development of specific diagnostic and treatment facilities for the physically ill but, unfortunately, has continued to see those with psychiatric illness as requiring continuous medical and nursing *custodial* care. This attitude has resulted in legislation to provide very large sums of money for services for the physically ill and for various social financial support programs. But there is too little money, too little emphasis and too little status for those services which by providing adequate psychiatric treatment would minimize the number of persons requiring the financial support programs.

It is not just financial assistance that causes concern. No matter how we try to disguise indigency and social assistance, there is no possibility for people to live satisfying and contented lives unless they have an opportunity to participate effectively in society.

Why Have Services Lagged?

The "Committee on Psychiatric Services" was appointed in 1955 to examine existing mental health services in Canada and to recommend new patterns of diagnosis, treatment and care. Reasons why the provinces failed to implement past recommendations were reviewed by the Committee.* These included:

> The lack of funds and ways in which they were allocated; tensions arising between interested parties connected with mental health services, e.g. the government, the University centre, etc.; lack of clearly formulated policies; public attitude; lack of personnel.

On the strength of these findings, a Committee on Mental Health Services was established on a permanent basis with provision for full-time staff and financial support.

Principles for Future Development

The Committee's recommendations arise from the central theme that

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Dr. Roberts is Executive Director, Verdun Protestant Hospital, and Assistant Professor of Psychiatry, McGill University, Montreal.

*The Committee's report, *More for The Mind*, was published in 1963 by the Canadian Mental Health Association. Much of the information in the article is quoted directly from this CMHA publication. Readers interested in the subject are urged to refer to it for further detail.

"mental illness should be dealt with in precisely the same organizational, administrative and professional framework as physical illness."

The five major recommendations provide for:

1. *Integration of Psychiatry with Medecine*

The aim is to have the psychiatric patient's condition recognized as an illness. Psychiatric consultation in a general hospital also permits evaluation and treatment of emotional problems in other medical patients.

2. *Regionalization*

Services should be established in centres of population on a regional basis so as to provide psychiatric care for the individual as close as possible to his family and place of residence.

3. *Decentralization*

Mental hospitals should be reconstituted under corporate boards of management with funds provided through the federal-provincial hospital insurance program. Local responsibility permits flexibility and adaptability in planning appropriate services.

4. *Continuity of Care*

This should be provided between various out-patient and in-patient facilities so that the patient may be looked after by the same treatment team throughout his illness.

5. *Coordination*

To prevent gaps and overlaps in services, and to promote maximum effectiveness, psychiatric facilities should be viewed as interdependent units in the over-all provision of mental health services to a community.

The Nurses' Role

The Committee gave much consideration to this role. Both in-patient and extra-mural services were discussed.

In-Patient Services

1. *General Functions*

"The nursing services represent the one member role that is in continuous 24-hour contact with the patient. The nurse is therefore responsible for continuity of care. She is also responsible, in large measure, for the 'atmosphere of the hospital milieu' and is, for most patients, the *therapeutic representative of the hospital*. . . . The skills required for this role include: An extensive familiarity with psychiatric phenomenology; some understanding of interpersonal dynamics, the ability to observe, assess and identify problems; the ability to report to and participate in the clinical team.

a) It is generally agreed that the nurse should have "understanding." Just *what* she should understand tends to be vague. The following is a minimum statement of the kind of understanding that the psychiatric nurse requires:

First, an understanding of the nature of a psychological disorder based upon a conception of normalcy. A basic aspect of this understanding would include acceptance of the idea that the patient has an *illness*, that disturbed behavior is an aspect of this illness and not evidence that the patient is bad, weak-willed, irresponsible, morally degenerate, or just putting on an act.

Second, the development of understanding beyond this can be made in terms of processes that are predominantly interpersonal, rather than primarily personal, intrapsychic, covert, symbolic and highly inferential. Thus, "dependency," "hostility," awareness of "anxiety," changes in object-relations, and the characterization of behavior in these and similar terms is preferable.

Third, there should be increasing *self-understanding* in the therapeutic situation in the sense that there is a growing awareness of personal reactions such as anxiety, hostility, dependence, acceptance or rejection. Greater awareness of such reactions, their acceptance by the nurse and an understanding of the way in which they can affect the development of her relationship to patients is vital. Her acceptance of and respect for *self* is basic to acceptance of the respect for others.

Finally, her understanding of these principles should help her realize the importance of her own role in patient care. She should come to understand that

> Every contact with the patient, whether in the performance of official nursing care or in some less directed capacity involves the nurse-patient relationship. The relationship can be either therapeutic or harmful.

The degree of understanding that the nurse possesses could reach any degree of complexity depending upon the type of setting in which she is working and the kind of therapeutic statement compatible with the frame

of reference of the whole working team.

b) Some continuous assignment of *social roles* by patients to nurses is inevitable — and can be unfavorable or favorable. Greater definition and possibly greater therapeutic effectiveness in some cases may be achieved by explicit structuring of the nurses' roles. Such a deliberate assignment and planning of roles, would, of course, be worked out in collaboration with the rest of the clinical team.

c) The ward is a *social system* in which the nurse may relate to patients through the informal or formal patient groups that develop on the ward. Many diagnostic and therapeutic activities can be carried out when the ward is viewed in this perspective.

d) The nurse should have a good knowledge of *occupational therapy* and its significance in the over-all treatment of the patient. Specific and detailed training in this area is not, however, necessary or desirable for her.

2. *Specific Functions*

a) Observation, recording and reporting.

Because of the considerable amount of time spent in these activities and because of their obvious importance, the Committee believed that they should be a major area of study by the nursing profession itself.

Recording procedure should be revised periodically to meet the needs of the *psychiatric* patient rather than those of the patient in a *general* hospital. In some instances, recording is a response to pressure to meet or to anticipate requests for information by medical staff and administration.

Lack of information can occur due to inadequate communication among members of the clinical team. Another problem is that information conveyed might be incomplete since the nurses doing the reporting may have only a partial view of the patients.

b) Patient care and physical care

The principle was set forth that a psychiatric nurse does not necessarily carry out all these functions herself. She may delegate part of them to others provided that these persons have been trained to carry them out, and do so under supervision. *The nursing staff may delegate certain functions, but cannot delegate responsibility*. One function that cannot be delegated involves *judgment* respecting the care of the patient.

c) Plant maintenance

Housekeeping functions have clear implications for patient care; therefore the psychiatric nurse must take responsibility for them. She should not, however, be required to carry them out herself.

d) Secretarial functions

Clerical duties such as answering the telephone, filling out forms and compiling lists, interfere with patient-centred activities. They should be delegated to a ward secretary or clerk.

e) Supervision

The role of the supervisor is not always clear. This person may be in charge of several wards without actually having had experience in some of those areas. This becomes particularly important in a general hospital where a nurse without psychiatric training may supervise a psychiatric ward as a part of a larger area of supervision.

Supervision should not be limited to administrative functions. It should be concerned with patient care, communication and coordination throughout the ward, and the professional development of members of staff.

It was recognized by the Committee that they had given insufficient emphasis to the role of the nurse as a respected colleague in the professional mental health group. It was also recognized that the traditional doctor-nurse relationship, amounting almost to "master and servant" roles, should be modified in the modern mental health facility.

3. *Aides, attendants and orderlies*

Ancillary staff should be considered administratively and functionally as part of nursing service since direct patient care functions are delegated to them during the 24-hour period. They should be removed from the category of "expedients" by providing them with adequate training and career opportunities.

Extra-Mural Services

The role of the public health nurse

is of the greatest potential significance in this area. With the general practitioner, she should occupy a central position in case finding, referral and post-discharge follow-up and rehabilitation at the community level. More attention must be paid to training the public health nurse to meet these responsibilities.

The *social worker* may be the liaison between the public health nurse and the patient, and relevant community agencies. No conflict should exist between the two roles in respect to follow-up care of discharged patients.

Psychotherapy — Who Gives It?

It is taken for granted that training in psychotherapy is a regular part of the training of a psychiatrist. The problem arises as to whether or not the paramedical professions should carry out psychotherapy.

Distinctions between counselling, case-work, and psychotherapy are artificial and impossible to maintain in practice. These are all therapeutic functions, and all are, or could be, psychotherapeutic.

When an attempt is made to characterize the various kinds of psychotherapy in an effort to decide whether any particular type is more suitable for social work, psychology or nursing, no firm distinction is possible. What might be termed a "relationship" between human beings — one ill, one well — could have a therapeutic effect on the ill member of the pair, even if the relationship is quite unplanned, and not specifically structured as "psychotherapy" in the first instance. What is called the "relationship" in psychotherapy is, in its simplest and supportive form at least, common to all personnel in mental health services — nurses, social workers, psychiatrist and psychologist — in the routine performance of their work.

The psychotherapeutic relationship, no matter how complex, is appropriate for any professional person on the clinical team provided that: training has been specifically adequate; in the case of the non-medical professions, the relationship is carried out with adequate and appropriate psychiatric collaboration; the procedure is clearly within the context and limitations of his or her profession.

Psychiatric collaboration should be structured to provide medical judgment and management in order to be sure that psychotherapy is appropriate and that untoward developments do not occur — or that if they do they would be recognized and handled appropriately."

Implications for Nursing

"All patients — the acutely ill, the mentally ill, the handicapped and disabled — should be provided with services appropriate to their needs."

What do we mean by "appropriate to their needs?" By WHO definition, health is a state of physical, emotional, social and spiritual well-being. All of our treatment efforts are designed to bring a patient as close to this state of well-being as the patients' resources (not his disabilities) and all of the social, personal and other factors will permit.

Can any one of us look at the health and welfare services available in North America without feeling a sense of guilt? We are all afraid of acute illnesses so we have developed elaborate facilities for their treatment. We all deny the possibility of the inevitable — death — so we create facilities of an elaborate nature in which to die while denying that such a possibility exists. We are, at the same time, apparently convinced that *we* will not suffer a chronic disabling illness or an accidental disability since the facilities provided for people with such conditions are woefully inadequate. We are short of physicians, nurses, social workers, etc., and, more important, we lack funds to develop worthwhile experimental projects.

Are our goals confused? While it may appear naive to review certain aspects of our way of life that are well known to all of us, but which few of us seldom think about, it would seem desirable to do so in order to set the stage for the discussion that follows.

The average Canadian community has developed a set of mores on the bases of which we are expected to follow a certain pattern of behavior. If we are able to follow this pattern, we

are acceptable to the community; if, for some reason, we cannot follow these mores we will be rejected by the community in which we live. Communities have two ways of expressing severe rejection: The individual is admitted to a hospital if he is considered to be ill, or, alternatively, he comes under the judicial, penal or reform system if considered to be unwilling, even though able, to conform to the mores of society.

The average resident in our communities is expected, during each 24-hour period, to involve himself or herself in constructive and productive activity — "work" — averaging about eight hours per day; to participate in recreational or similar pursuits for about the same period of time; and to have a period of rest which, for the average person, is about eight hours.

Why do people follow this pattern? It is easy, but too superficial to suggest that we do it because we grew up in this particular culture. Certainly, most of us have never given the matter any thought. We follow the routine almost like zombies even though we frequently feel terrific resentment againt the demands made upon us.

The average person rests six, seven or eight hours per night because, by his early twenties, he has learned the routine he must follow in order to function reasonably well. Three main factors are involved in work: Satisfaction for ourselves from our own activities; recognition of the value of our activities by society; and the means to obtain a living. Recreation appears to represent a change of activity and an opportunity to do something we would like to do without being dependent on it for income.

The ability and opportunity to follow the foregoing routine, together with a positive identification with one or more people in the community are the most important factors in determining the extent to which our lives are satisfying to ourselves and useful to our community. Most psychiatric patients are unable to follow this routine. They may be unable to work because of illness; participation in recreational activities is difficult or impossible; they may be unable to get sufficient sleep or rest which, in turn, disturbs the whole routine of daily living.

People in our society appear to be ever more confused. They seem to be increasingly involved in a search for satisfying activities as the status and respect for work changes. I must express a great deal of personal concern about the attitudes of health and welfare workers with regard to work. I often wonder why people work. I am satisfied that one works in order to gain personal satisfaction and that many of our present social and professional difficulties are due to overemphasis on making a living within the shortest possible work week. Too little emphasis is given to *personal satisfaction* and to *social recognition* of the part we play in our society.

Traditionally, our communities have placed a high value on work and participation. The well-to-do who do not work are referred to as "playboys" and "spendthrifts." The only people excused from work are the sick or dependent. All others who do not work are described as "lazy" or in some way undesirable. The dependent group includes the very young and the very old who, either because of lack of development or because of progressive aging, are unable to participate in work. The introduction of various welfare programs and more particularly unemployment insurance has further complicated this matter. The Unemployment Insurance Fund as presently administered is misnamed; it is being used to guarantee *income* not *employment.*

Socially, it would be much more appropriate to ensure that work would be available for everyone than to be concerned with income maintenance. The guarantee of work would ensure income maintenance. Income maintenance alone may well interfere with the normal motivations of our society. There are many people who will work for a certain length of time in order to qualify for unemployment insurance and then will not work again until their benefits have been used up. What does all of this mean so far as psychiatric services are concerned? What does it mean to nurses specializing in this field?

There is no doubt that it was formerly necessary to work long hours because we did not have the means of production that are now available to us. As these improved, it became possible to shorten work hours and still meet the needs of the community. The shortened work hours have accentuated the importance of recreation. Furthermore, it is quite obvious that most workers engaged in mass production are unable to meet their needs for personal satisfaction and social recognition. Their dissatisfaction is continuously expressed by demands for more and more income with less and less work. People do not talk about the lack of personal satisfaction or the status of the service they perform since this requires the admission of a personal problem, or leads to criticism of one's superiors or the organization where one is employed. Facing a problem in this way is unacceptable to most people!

It is in this area that health and welfare workers are most confused. Professionals want a shortened work week, higher salaries, and other of the fringe benefits obtained by labor. At the same time they wish to obtain personal satisfaction and social recognition for the services they perform. *It is quite possible that these two objectives are incompatible.*

Patients are not sick or disabled during any particular eight-hour period of a 40-hour week. They become sick at any time and, presumably, require treatment until they are better. It is not possible to develop a satisfactory treatment program based on the performance of professional services during a 40-hour week or 36-hour week between the hours of nine and five, Monday through Friday!

We, as professionals, say that we are part of the community in which we live and that we are faced with the same pressures and mores as are other people in the community. Presumably we deserve the same rewards and benefits as do other people! But *is that what we really want?* Is it possible that we are short of personnel in our fields because we do not provide sufficient opportunity for personal satisfaction and social recognition? Is it possible that we are responding to community pressures and behaving like the average person when we should be setting an example and giving leadership?

If we look at the present position regarding the provision of health services, we find that we are faced wth a serious shortage of professional workers. At the same time we are faced by demands for higher levels of education, shorter work weeks, more vacations, etc. The outcome may well be less and less service to more and more people. One can justifiably ask if the end result of our professional education is to provide treatment services to those who needs them or to take care of the needs of the professionals concerned.

Conclusion

In spite of the introduction of drugs and other forms of psychiatric treatment, it is quite apparent that the identification of the patient with his therapist and recognition of the value of reality in his everyday life are still of primary importance. It seems necessary to base the treatment of psychiatric patients on functions closely related to day-to-day living. It is in this area that one arrives at an important conclusion regarding the role of nurses and other personnel in psychiatric services. In the psychiatric setting, the therapist becomes much more a person with whom it is hoped patients will identify and who, it is hoped, will provide an example by her attitudes and habits of daily living. The therapeutic activities have to be related to life situations and to the accomplishment of satisfactory social relationships if the patient is to benefit from the treatment and return to the community with a satisfactory adjustment.

A poet can survive everything but a misprint. — OSCAR WILDE

Changing Attitudes and Images

DOROTHY DIX BURWELL, M.A.

Education is the keystone to attitude and image change in psychiatric nursing.

Scientific enquiries into the nature of mental health and mental illness have resulted in many changes in the field of psychiatry. The question arises, however, as to whether or not nursing is keeping up with these enquiries; whether or not it is making the best use of the knowledge gleaned from the various disciplines. A study of the attitudes and images found in psychiatric nursing and how these are being changed or might be changed will be the theme of this article.

Drever* defines *attitudes* as a more or less stable set or disposition of opinion, interest, or purpose, involving expectation of a certain kind of experience, and readiness with an appropriate response. In the wider sense of the word, he describes social attitudes as being sensitive to social relations, social duties or social opinions.

He defines an *image* as a revived sense experience . . . as seeing with the mind's eye . . . usually somewhat schematic, capable of representing any one of a class of objects.

In nursing, many areas must be considered when changing attitudes and images. Since the patient is our main focus of attention, or the centre of our force field, *he* should be considered first. Indeed, the very fact that some members of the profession do make sincere attempts to consider him first, and plan their activities around his care rather than around routine and procedure, indicates an attitude of kindly concern.

In many hospitals and agencies, the psychiatric patient is being considered as a human being with the dignity and rights, if not the privileges, afforded such in our society. One example of this can be found at Boys' Village, in Toronto, where all staff members, nurses included, must have a baccalaureate degree in preparation for further training as counselors in charge of delinquent, disturbed boys. Here one finds attitudes of concern for the boys. Restrictions placed upon them are imposed with dignity. Just as patients in day care centres and in some hospitals plan activities with nursing and occupational therapy staffs, so these boys help to plan their own daily activities. They are accepted as important human beings, regardless of how unacceptable their behavior might be.

CUSTODIAL CARE

Prevailing in this type of care is the traditional prison attitude with a highly-controlled setting concerned mainly with detention and safe-keeping of the "inmate." The patients are considered to be very different from so-called *normal* people, to be quite irrational and insensitive, unpredictable and even dangerous. Their mental illness is attributed to poor heredity, organic change, etc. The staff do not really try to understand the patients, nor do they become engaged in meaningful relationships with them.

Mrs. Burwell is Lecturer in Mental Health and Psychiatric Nursing, School of Nursing, University of Toronto.

* James Drever, *A Dictionary of Psychology*, Gr. Britain, Aylesbury and Slough, 1960, p. 22.

Pessimism, impersonal patient-staff relations, and a watchful mistrust permeate the agency.

The patient in this setting is of less importance than the staff. This is particularly noticeable when visiting dignitaries are introduced to the members of the agency. How often does one see them introduced to *patients?* Even the nursing office staff seem to be more interested in equipment and supplies and in listening to the supervisor and her problems, than in paying a visit to some withdrawn patient. The administrative staff, who set the tone of the agency and establish attitudes and images within it, are involved in building an autocratic, rigid status hierarchy where a one-way flow of communication takes place — probably in the form of written memoranda. Decision-making is carried out only at the top level; power flows from this upper echelon downwards. This imposes a threat to the staff, particularly to those who may wish to make suggestions for change.

THE THERAPEUTIC COMMUNITY

A more *humanistic* orientation is evolving. This conceives of the agency as a *therapeutic community* wherein interpersonal and intrapsychic sources of mental illness — for example conflicts within the individual — are sought out. A more personal approach is used in patient care; staff members are more optimistic about the possibilities of patients recovery in such an environment; the surroundings and furnishings are homelike. The nurse *does* become involved with the patient, while at the same time keeping her manner professional. Potentialities for *healthy* rather than unhealthy behavior are considered to be of paramount importance. What can Mrs. Jones do well? How can we help her to build positive relationships?

The agency administrators collaborate more with staff in this setting. Authority becomes decentralized, with each patient unit having its own medical administrator and professional and technical staff. Communication, verbal and non-verbal, is considered important between patient and patient, patient and staff, and staff and staff. Staff members, from aides and attendants to the psychiatrist-in-charge, meet regularly to discuss patient care. The public health nurse who refers patients to the agency and assists in their rehabilitation is included in these discussions. The family is also considered an important adjunct to the patient's recovery. Family members are taught how to help prevent further breakdowns and to recognize the fact that mental illness is not a disgrace. This type of therapeutic program calls for a deeper understanding of the meaning of mental health itself, and the dynamics that lie behind behavior. The nurse needs to be knowledgeable of certain criteria of mental health; the needs of people and when these seem to be distorted; the ability of a person to adapt to his environment; the ability of a person to integrate into his personality certain events that create stress within his life and sever relationships with other meaningful persons within his home and community.

EDUCATION FOR CHANGE

How is change accomplished? How does the nurse who is accustomed to carrying out custodial care become one who uses a more humanistic approach, who believes that meaningful interaction and understanding of patients is the keynote of patient care? In my opinion, the answer lies in education.

In the education of both young and more experienced nurses, the primary aim is to create a felt need for this kind of patient care; without this we make little or no progress. Secondly, we must assist the individual in her search for the facts and patterns of behavior best suited to the situation at hand. Finally, we must help her to apply these findings in her nursing care and to evaluate the results.

These three steps Whitehead terms "the rhythm of education." In the first stage, *first apprehension,* new behavior, knowledge and attitudes have the "vividness of novelty." Next, the *stage of precision* calls for an acceptance of a given way of analyzing facts; the third stage is *generalization,* with the fruition or final goal of the training process, the final success, wherein facts may be applied in many varied situa-

tions. If learning of new attitudes and images is to take place, all three phases are necessary.

The content of this education has already been indicated. It should help the nurse to feel secure enough to look for meaning in the patient's behavior as well as in her own; to see that the patient is not always behaving in certain ways just to annoy, to be destructive or to create problems for her, but that he has ways and means of protecting himself against anxiety-provoking situations. He may keep his distance, for example, by withdrawing from relationships, or he may hit out at others, or become very demanding. But these she will recognize as pleas for help; help in coping with such unproductive behavior. As a leader, the nurse who has the longest and most intimate contact with the patients must become involved in such processes. She must be taught how to become involved professionally without losing her professional role. In doing this she must learn to grow herself, and to develop healthy interpersonal relationships. She must learn about the forces at work within herself as well as within the patient.

METHODS OF TEACHING

1. *The Interaction study:* One of our students was assigned to care for a nineteen-year-old patient who was herself a student nurse. The patient had been admitted to hospital appearing very depressed; for several weeks she showed no evidence of recovery. Everyone was kind to her, but she merely brushed them off in a hostile manner; nothing seemed to be helpful in bringing her out of this depression. She looked very downcast, and would turn away from help extended to her. Our aim was to give her all the attention she needed without commenting on her behavior, or without letting her drive us away. This was difficult at times, as we symbolically became the "bad" mother who had deserted both her and her father. After several days she began to show some interest in us; now was the time for stage two. We confronted her with her histrionic behavior, such as her open defiance of practices within this hospital. She responded surprisingly well. She recovered to the point where she was re-admitted to her own school of nursing. These interactions called for detailed daily analysis of her and our behavior. This daily record was called an interaction study.

2. *Group discussions:* With a class of 30 to 40 students or registered nurses, discussion groups of 15 are formed with an instructor and a psychiatrist present as resource persons. During the first session, students are informed that it is their responsibility to bring problems in nursing care to the group; discussion follows, and questions are raised. The resource people then teach for 30-60 minutes using some of the problems presented. The value of this type of teaching lies in the ability or inability of the instructor to adapt herself to group work. She must not rush too quickly into content until the students are thoroughly stimulated. If a nursing care problem is not at hand at the moment, students themselves often volunteer to find a topic for group discussion. This is when content becomes meaningful to them when such question are raised as: "What is the basis for delinquent behavior?" or "Why do patients want to run away from hospital?"

3. *Role playing:* Discussions often lead to the use of this psychodramatic technique. Three volunteers remain outside in the hall and enter the room one at a time so that each may demonstrate how she would interact with a patient, and cope with a particularly difficult problem — for example, having Mrs. Jones, a very withdrawn patient, take her daily bath. A staff member plays the role of patient. Students in the psychiatric field, or registered nurses working on staff can enact their own roles psychodramatically. The discussion that follows usually indicates that members of the group have identified very closely either with the nurse or with the patient. Spontaneity is the keynote of such teaching. The student does not know ahead of time what the patient is going to say or do; she responds as she would on the ward or in the home.

Psychodramatic methods seem to assist those observing, as well as those taking part, in gaining insight into their

own motives, anxieties, projections, etc. The nurse now knows what it feels like to be in another person's shoes, perhaps as a patient or another nurse, or in her own role seeing herself as others in the group see her. With these methods, nurses take an intensive look at their own behavior, as well as that of the patient. The group members become more ready to accept problems they may encounter. They are stimulated to want to know more.

I have used this method with all categories of staff and public health nurses. I have never found it to fail to involve the learner. It is not without its stress factors, however, but these, too, can be brought out in discussion.

4. *Case-incident:* This method of teaching is also effective in changing attitudes and images. A situation from the hospital or public health field is presented to the group for discussion; principles evolving from this can then be applied in the care of the patient.

DIFFICULTIES ENCOUNTERED

1. One great problem in developing changed attitudes within our profession is the distaste many nurses have for the suggestion that they *reveal themselves* to their colleagues. Since this is essential to the functioning of the "therapeutic community," some technique of analysis of conscious behavior must be sought. It will often bring to light our attempts to impose our own mores and folkways on others.

2. *Fear of reducing the status of the nurse* image is an equally strong objection to change. Despite much liberalization professionally, some nurses still yearn for the acknowledgement of their position in as simple a matter as having a class of students stand when the instructor enters the room.

3. *Prejudices* are difficult to overcome. Marie Jahoda says:†

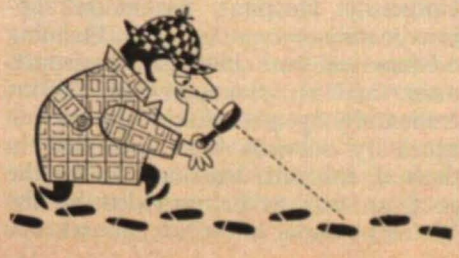
A prejudice fulfils a specific irrational function for its bearer, and is a pattern of hostility in interpersonal relations directed at an entire group or its individual members.

Allport points out that prejudice is related to an overgeneralized and therefore an erroneous belief.** This says most succinctly what has happened within the nursing profession. The disfavor connected with the mentally ill connotes a lack of understanding and empathy with members of the community, and even members of the profession, who have been ill. The erroneous belief is that once ill always ill; there is a failure to understand that therapy *can provide a corrective emotional experience* — a learning process.

When we are confronted with the question of taking a student who has been mentally ill back into the school of nursing, we tend to hesitate. We somehow expect that she will continue to show untoward symptoms; that she must be given extra careful supervision. Perhaps she may not even be allowed to return. Perhaps the *staff* have some attitude changing to do. The image of the person needs to change from one of potential *weaknesses,* as the mentally ill are often viewed, to one of *potential strengths.*

† N. W. Ackerman and M. Jahoda, "In Speaking of Prejudice Towards Groups."

** Gordon Allport, *The Nature of Prejudice,* New York, Doubleday, 1958, p. 12.



You don't need to be Sherlock Holmes to know where these tracks lead: to the CNA convention in St. John's, Newfoundland, of course. Plan to be among the hundreds of nurses making tracks for this big event, June 14-19.

"Stone Walls and Iron Bars"

LORRAINE F. MILLER

Even today there are groups of individuals for whom stone walls and iron bars form a prison atmosphere. We need only look at some of the buildings that house the mentally ill in our Canadian communities to recognize that, in truth, these patients are essentially prisoners of their environment.

The mentally ill have suffered from the reaction of the public to their illness probably more than any other group. Families became ashamed to acknowledge mental illness in their circles, and this attitude frequently resulted in the relegation of the unfortunate individual to a back room, with no treatment attempted and no effort made to utilize or stimulate the intelligence and capabilities that he might posses. Even today there remains a feeling of stigma, a reluctance to accept mental illness, among many of our citizens. Fortunately, a gradual change is evolving. There is growing recognition of the fact that much can be done for the patient; that there is a very real challenge facing those individuals concerned in any way with the care of the mentally ill.

People of all ages ranging from the very young to the very old, may suffer from varying forms of mental illness, with varying degrees of severity and exhibit many different symptoms. It has been estimated that one person in eight, at a single point in time, suffers from a psychiatric disorder. This indicates that the likelihood of its occurrence in any one person's lifetime is indeed great. Further estimates reveal that 10-50 per cent of all patients attended by general practitioners show varying degrees of emotional disturbance. Despite the many advances that have been, and are being made, in understanding human brain function, we still have a large percentage of our population who suffer from psychiatric disorders. These people constitute a major health problem.[1]

One of the major problems facing the mentally ill patient is the adjustment that he must make following treatment.. Extensive therapy and fairly lengthy hospitalization may have been necessary in his treatment program. His attitude toward a return to community life and activity is hesitant. He feels the need of continuing support and guidance; help to assist him in complete recovery from his illness; support to prevent recurrence or breakdown with resultant readmission. It has been[2] proven in studies in the U.S.A. that some form of aftercare, follow-up or supportive home care program can reduce readmission rates from 35 per cent to about 15 per cent. There is proof also that drugs play a major role in reducing readmission, and that home care programs are less costly than hospital care programs.

In an effort to establish factual information regarding the usefulness of follow-up home care for discharged patients, a research study was undertaken in the psychiatric department of University Hospital, Saskatoon[3] approximately two years ago. Planning conferences were held in the department, and representatives of various community agencies that might provide necessary services were included in these discussions. Nursing care for the program was to be provided by the Victorian Order of Nurses; housekeep-

Miss Miller is District Director, Victorian Order of Nurses, Saskatoon Branch, Saskatchewan.

ing services by the Family Service Agencies.

For many years the V.O.N. had been providing nursing care for large numbers of the aged and senile psychotic in the community. The nurses had acquired skill in the management of these patients; had developed an understanding of the strain on the family; had played a sympathetic, supportive role in meeting the specific demands involved in the care of such patients. They occasionally encountered acutely disturbed patients; alcoholism and suicides were infrequent emergencies. In general, however, they had little occasion to work with the acute, mentally ill patient. Referrals on discharge from hospital were almost unknown, apart from the occasional request for supervision of patients with mild, postpartum psychosis.

The *objective* of the visiting nurse in a psychiatric home care program is essentially the same as the objective of the nurse on the psychiatric ward of the hospital. Her *function* is to continue in the home the nursing care program devised in the hospital to meet the needs of the individual patient. In both instances nursing psychotherapy is important. Her first concern is to perform her traditional nursing duties and to provide whatever physical care the patient may require. Her supportive role includes both patient and family. Perhaps the most important part of this is *listening* — to the patient and to the family. It may involve more time than it would take to give a bed bath or treatment, and it is perhaps a difficult skill to acquire. Nurses, especially visiting ones, seem to function on a clock-like schedule. To fulfill this listening function and remain patient and helpful, demands that the nurse be aware of her own reactions, and avoid entanglement with those of the patient.

Interpretation is always an important function of all team members, and of nurses especially, for they see the patient most frequently: Interpretation to families of the physician's orders so that they understand why drugs must be given regularly; the need to make families understand that patients can be cared for at home; the assurance that help is readily available. The supervision of the patient's physical well-being, stress on rest, diet, relaxation, and activity, are all included in the nurse's supportive program. Family routines and patient's needs are correlated. The nurse assists in planning programs to "go along with" family work and activity. The physical health of the patient is observed closely; any indication of physical illness is reported to the family physician. The nurse includes health teaching and supervision for all members of the family as part of her regular visit. It is important, always, to remember that the home care patient is greatly dependent on the members of his family and others. They must receive supervision and support if they are to maintain their level of well-being.

A third aspect is that of referral of problems beyond the scope of the nurse to appropriate professional personnel. The nurses have found that, in referring to physicians and other team members of agency personnel, they increase their understanding. Shared problems are easier to solve.

Reporting takes skill and the nurse frequently requires assistance. Forms have been set up to aid her in carrying out this responsibility adequately, but the report to the team conference, the recording on charts, and preparation of documents for referral is demanding. Nurses still are inclined to be too brief, too concise. Psychiatric illness demands alert, comprehensive observation and reporting. Experience has improved the nurse's ability to fulfill this most important function.

Last but not least, cooperation and coordination with other members of the psychiatric team is most important for the visiting nurse. True, she has cooperated with others for years in planning for patients, but now she must do so more fully in planning comprehensively for the patient and the family. Her visits must be organized with an awareness of other team members' functions and their activities, otherwise problems may be created, and goals for patient care lost.

What can be done to ensure a well-prepared staff, capable of carrying out the demands of such a program? We

were unusually fortunate in that all of the nurses on our staff had some basic psychiatric nursing experience. This was a good foundation on which to build. The entire staff spent a full half-day in the psychiatric department of University Hospital observing all phases of the treatment program. A conference was held with the department heads. Each nurse was given an opportunity to discuss her fears and her feelings; to ask questions and to receive advice and guidance. Reading material was made available; throughout the year the staff members attended regular psychiatric seminars and derived much help and inspiration. Inservice education meetings were planned to keep new and present staff interested and up-to-date in relation to treatment, drugs and therapies. Arrangements were made for one senior nurse to attend a special psychiatric nursing assembly, and to bring a report back to the remainder of the staff.

The need for each nurse to explore her own feelings in accepting the responsibilities involved in such a program was very evident. Group discussions with one of the team psychiatrists provided an opportunity for questions to be considered and answered. Counselling was made available to the nurses as required. It was found that the senior social worker in the department was very helpful in interpreting patients' needs. This had special significance when social and environmental factors contributed to a patient's condition. Each nurse was required to think more seriously about her approach to the patient and, in her endeavors to improve her interpersonal relationships, her ability to counsel and to appreciate the problems of the mentally ill patient, she improved herself and her own ability to achieve fuller understanding.

The change from physically active nursing to supportive nursing is not always easy to make. Supervision and guidance were provided to assist the nurse to achieve satisfaction from this type of visit. Again, the previous psychiatric experience of the staff proved a valuable background. Learning to listen, and then learning to record, took special effort. Each nurse had to learn to analyze and observe; to identify normal behavior in situations; to record her impressions accurately.

Since the inception of the program in January 1962 and the active participation of our Branch in it, some 20 patients have been referred for nursing care. Of this group, five required some active nursing care as well as supportive care; one has been on the program since its inception. The majority of these patients (14) were over 65 years of age, and were referred from a special research project of the University Hospital Department of Psychiatry. Six patients were 25-65 years of age. There were three male and seventeen female patients. Eight were discharged from the program during the first 18 months of operation. Three of these have carried on independently, without any supervision; two are still carried by V.O.N. for nursing care once or twice weekly, both because of age and residual paralysis; two are seen in the outpatient department of the hospital; one was discharged to a provincial mental hospital. Four of the 20 patients have had readmissions for varying periods — none for any great length of time. On discharge they were again "on the program." In 1962 the total patient days for all those on the home care program was 6,123. These people received nursing care, physiotherapy, social worker services, occupational therapy, housekeeping, orderly and physician's services, as required. Drugs were provided for some, transportation to and from clinic for others. All patients, of course, did not receive all services.

Is such a program valuable? Are we achieving our objectives? One has only to observe the response of the patient to the support and consideration he or she receives in a home setting to answer "yes." However, we must admit that, though we are favorably impressed with the results we have observed, we recognize that this type of program is a very demanding one. It requires combined and concentrated efforts by all team members; it can be frustrating and discouraging, but with team effort it can become rewarding and successful. Communities are gradually recognizing that they must take more responsibility for

the care of the mentally ill. Acceptance of new programs is becoming more wide-spread. Families are grateful for the proffered help, and are willing to participate in programs for home care when they are adequately guided by skilled personnel. "Stone walls and iron bars" can be broken down by tender, loving care, understanding, appreciation, hope and faith.

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3. This project was supported by the Saskatchewan Department of Public Health, and the National Institute of Mental Health, Washington.

TOM

A Patient with Schizophrenia

CAROL QUINN

A tall, thin teenager shuffled quietly about the ward in the psychiatric hospital. He appeared stooped and dishevelled in pajamas and dressing gown. Usually he kept to himself, spending most of his time lying on his bed, head buried in his arms. When spoken to, he responded politely in a low-pitched, confidential tone of voice. His conversation was difficult to follow since he jumped from one topic to another without completing a sentence — a characteristic known as "word salad." He stopped talking when anyone, apart from his nurse, approached, and watched the person with suspicion until he left.

This was Tom — a patient with schizophrenia. His parents first noticed his withdrawal from others when he was nine years of age. At that time he had moved with his parents from a small town in the west to a large eastern city. He preferred to remain indoors, did not play with any of the neighborhood children, had no friends, and did not belong to any group. His school grades fell and he barely achieved a passing grade at the end of the term.

The school nurse was responsible for Tom's psychiatric referral. The boy had been involved in a fist fight with a classmate shortly after the Easter examination results were announced. This, along with his poor grades and inability to relate to people, convinced her that he needed professional help. Tom came to the outpatient clinic with his father and was admitted to hospital the same day.

Miss Quinn was a third year student at the University of Toronto School of Nursing when she prepared this study.

FAMILY BACKGROUND

The psychiatrist's interview with Tom's father revealed that the latter was a rather domineering individual who demanded perfection from his two children. In answer to a simple question about his job, he gave a detailed account, complete with statistics, of the family business. He emphasized that they lived in a well-to-do section of the city and that his son lacked nothing of the material comforts of

life. In later interviews with Tom, a picture of his mother emerged as a fastidious person who enjoyed housekeeping and entertaining and who was very conscious of her family's social standing in the community. Both parents seemed genuinely concerned about their son's illness and the possibility that they had failed in their role as parents.

HOSPITALIZATION

Tom was compliant to the admission routine although at times he seemed confused and had difficulty understanding directions. When the nurse asked him to sign a clothing list, he slowly read the words aloud seemingly without comprehension, and finally wrote his name. He was placed in a room with ten other patients where he was under continual observation — the usual procedure for a newly admitted patient. He seemed out of touch with reality as he lay on his bed mumbling to himself.

At first, the boy was careless about his personal hygiene unless reminded about it by his nurse. He spent much of his time performing odd exercices, such as touching his nose several times with his finger, which he said he did daily to keep physically fit. He often tried to read but found this difficult since he could not concentrate. I discouraged reading at this time because the inability to concentrate upset him. I encouraged him to watch and participate in card games, checkers and other such activities.

Three days following Tom's admission, the psychiatrist prescribed chlorpromazine 50 mg., q.i.d., orally. Chlorpromazine (Largactil) is a tranquilizer that is given in psychoses and confusional states as well as for anxiety and tension. Patients receiving this drug may feel drowsy and dizzy, have slurred speech, and complain of a dry mouth, nausea and vomiting, photosensitivity, and nasal stuffiness. Tom had the side effects of dizziness, drowsiness, and slurred speech, all of which subsided after his system became accustomed to the drug. The symptoms of his illness were significantly, but not completely relieved by the drug.

As part of the hospital routine, an electroencephalogram was performed. An abnormal, low amplitude spike and low wave burst pattern were observed. These occurred more frequently on the left side in the temporal and occipital lobes — a pattern suggesting the presence of an epileptic component which might present a problem in diagnosis and treatment.

Tom confided that this test had frightened him. The wires around his head convinced him that they were meant to prove him "insane". I tried to explain in simple terms the purpose of the test, but he was so confused and apprehensive that he understood nothing.

PATTERN OF BEHAVIOR

Tom told me that his problem was "mainly social." He found it difficult to talk with others, he lacked friends, and he believed that all his classmates as well as all the patients disliked him and were trying to make him appear "crazy." He felt different from other people and claimed that they were aware of this difference and were constantly watching him. He believed himself to be "the talk of the town" and the "centre of attraction" on the ward in an unpleasant way. The patients, he was convinced, were really psychiatrists and psychologists posing as patients so that they could watch his reactions to ward situations. He felt that the staff were suspicious and waited to see what he would do next. When I asked if I bothered him, he replied, "Oh, no! You are my nurse. You have to observe me so that you can help me." To reduce his feelings of being observed, I tried to direct him to various group activities where I could watch the entire group. I made certain that I had a definite, logical purpose for being in a room with him.

When he complained of people talking about him, I tried to reassure him that no one was against him or talking about him. I did not argue with him, however, and accepted his feeling of persecution.

A few days following his admission, Tom wrote a letter to the staff expressing a desire to do the right thing to help himself and others. He drew a confused diagram indicating his relative

position to the staff and outside world; he described in detail his concept of his two different personalities — friendly and extroverted outside of hospital, but self-centred, introverted, and concerned because everyone thought he was "crazy," while in hospital.

Tom had delusions of reference wherein the behavior of others had meaning for him. Even inanimate objects became symbols that had special significance. For example, when a door fell from its hinges, Tom insisted that this happened so that his reaction to it could be tested and his sanity determined. These delusions were real to him; he retained them despite objective contradictory evidence.

When his mother visited, Tom ignored her. He told me that he was too dependent on her and felt awkward when in her presence. He seemed to harbor guilt feelings because of his conscious desire to rebel against her wishes. He appeared surprised and relieved when I explained that many teenagers feel this rebellion against parental authority.

Tom frequently became upset and panicky. At these times he would complain of typical anxiety symptoms: headache, tachycardia, weakness, tremor, "butterflies" in the stomach, and a feeling that something dreadful was going to befall him. He would become agitated, excited, and restless and would pace the floor. His voice would become higher and louder as he talked about his fears. After verbalizing them, he usually appeared calmer.

Two weeks after admission, Tom became quite interested in his appearance and deportment. He insisted that the nurses precede him when entering a room and held the door open for them. He told me that he felt better being able to "act like a man again."

A week after this, he suddenly became more tense and withdrawn. His conversation was again confused and bizarre. The chorpromazine was increased to 75 mg. q.i.d.

TREATMENT

Extra Attention

In a conference with the nursing staff, the psychiatrist stated that Tom needed extra "T.L.C." He said that the boy needed to feel accepted and to have someone to whom he could confide his feelings.

I spent as much time with him as possible. I sat, stood, or walked with him even when he showed no inclination to talk. He revealed his irritation by giving short, incomplete replies to my questions while looking beyond me. When this happened I would excuse myself and leave him for about 15 minutes. Usually, by the time I returned, he would be ready to talk.

Occupational Therapy

The therapist provided Tom with copper work that required moderately fine movements. Because he had difficulty concentrating and understanding directions, she repeated them several times. She encouraged him frequently by praising his efforts; she would then tactfully explain what he could do to improve his work. He became discouraged easily and was suspicious of any criticism. He worked intently, albeit awkwardly, on his project and seemed to derive satisfaction from it.

Electroconvulsive Therapy

A month following admission, Tom was put on an electroconvulsive therapy program (also referred to as electroshock therapy). This treatment consists of the administration of controlled electrical impulses to the brain thereby inducing a convulsion. It is used frequently in schizophrenic conditions.

Tom was quite apprehensive when the treatment was explained to him. He was assured that he would feel nothing other than suddenly going to sleep.

Food and fluids were withheld before each a.m. treatment. Tom bathed, had his vital signs recorded, was given sodium amytal to promote relaxation, and atropine to reduce secretions. Immediately prior to the treatment, scoline, a muscle relaxant, was given to modify or reduce the severity of the seizure and to decrease the danger of fractures.

The electrodes connected to the machine were placed on the skin in front

of the temples and the shock was administered. Four nurses held the patient at the shoulders, wrists, iliac crests and above the knees to prevent him from falling or fracturing any bones. The attendants observed his toes to see, by their flexion, when the seizure started and ended. An airway was inserted and oxygen and carbon dioxide were given until his respirations returned to normal.

The patient passes through several stages during the seizure: an aura in which he may gasp or cry out; a tonic phase in which body and limbs are rigid and he becomes cyanotic; a clonic phase in which jerky movements of the body occur as a result of the alternate contraction and relaxation of muscles. After the seizure he usually feels exhausted and sleeps for several hours.

PROGRESS

Shortly after beginning the E.C.T., Tom expressed a desire to study and had his parents bring in mathematic and language books. He became more interested in people, and frequently asked patients and nurses to join him in card games. He even offered to teach others the games he knew. I could see that he still felt uncomfortable but was forcing himself to interact with others. The psychiatrist felt that this was a definite step toward improvement.

He became interested in the outside world, asked about current events and read newspapers and magazines avidly. His attention span, however, was short. He was quickly and easily bored and changed activities about every 20 minutes.

It is interesting to note that Tom's ideal of a boy his age was, "one who is aggressive, athletic and one of the gang." His aim, he said, was to strive to resemble this ideal, although he felt that he would fail in the attempt. He stated that he should learn to accept himself as he was — a weak, uncoordinated boy who "just likes girls."

Tom was allowed out on the hospital grounds when accompanied by a nurse or attendant. He attended Sunday church services and weekly dances held for the patients. Although he was a poor dancer, he seemed to enjoy himself on these occasions. He became more cheerful and relaxed. I noticed however, that he still tended to be suspicious of other's motives. He was still ill and had not yet completely adjusted to reality.

SUMMARY

To be mentally healthy, an individual must be able to make an active adjustment to his environment. He must have unity of personality and be able to maintain a stable, internal integration or ego which remains intact. He must have the ability to perceive correctly the world and himself.*

Tom had difficulty in all these areas. He could not adjust to his new school, home or the expectations of his parents, so he withdrew emotionally. He developed an inaccurate perception of the world, those around him, and himself. In his ideas of reference, he used the mental mechanism of projection, attributing to others thoughts and feelings, really his own, directed against himself. His lack of motivation was reflected in his neglected personal appearance. He appeared to be almost dull at times since he was unable to follow simple directions because of his confusion and inability to concentrate.

The psychiatrist did not believe that Tom's improvement was entirely due to the shock therapy. He felt that it was mainly brought about by the neutral environment of the hospital and the support and encouragement of the staff.

Tom was discharged to his home with instructions to return weekly to the outpatient clinic for further psychotherapy. His parents had had several conferences with the psychiatrist and seem eager to help their son adjust to life outside the hospital.

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* Ruth Kotinsky and H. Witmer, *Community Programs for Mental Health*, Harvard Press, Cambridge, 1955, p. 307.

He was a bold man that first ate an oyster. — JONATHAN SWIFT

A NURSING APPROACH TO TWO TYPES OF NEUROSIS

KAY PARLEY, R.P.N., B.A.

Others have rejected her. The nurse accepts her even though her behavior is frequently irritating. Only by accepting can she provide her with the assurance that she is a worthwhile human being.

Hypochondriasis

Mrs. Bradley, a middle-aged housewife, was transferred from surgery to medicine following a sub-total gastrectomy. She complained of abdominal pain that was relieved only by taking "nerve" pills. Various tests and examinations were performed to rule out the possibility of a marginal ulcer or of carcinoma of the gastric stump. No evidence of organic illness was found. The condition was diagnosed as post-surgical depression in a neurotic personality, with a strong element of hypochondriasis. Symptoms included sweating, pounding heart upon awakening, weakness and numbness of the legs when walking, deafness and buzzing in the ears.

The physician explained to Mrs. Bradley that her illness was of an emotional nature and had no physical basis. This was hard for her to accept. She found it difficult to believe that emotional and social forces could contribute to illness.

The wisest thing for the nurse to do in such a situation is to be a good listener; to listen completely and intently to the patient's own story of the history of her illness; to offer no comment except, if necessary, to show her that her fears and discomforts are understood. The nurse should attempt to divert the patient's attention from her physical symptoms and complaints. Since Mrs. Bradley shared a room with a patient who had a similar diagnosis, this was a difficult undertaking. Great care was taken in questioning them about their symptoms so as not to lead them on to imagining more. We made it a rule *not* to greet either with the question: "How are you today?" Physical treatments were kept at a minimum and carried out without undue fuss.

A patient with a psychoneurosis should be encouraged to participate in group activities. Mrs. Bradley discovered a small group of patients with like interests and participated actively with them; she took a more passive role when in larger groups. Eventually, she became interested in occupational therapy and accepted responsibility for making coffee for the group. Through group discussion, an attempt was made to help her gain insight and plan for the future. Although her insight was limited, she learned that if she didn't think so much about her stomach she wouldn't suffer as much abdominal pain.

It was impossible to discontinue Mrs. Bradley's medication at her discharge since these "nerve" pills brought her some relief. We have to be able to admit that these patients do need crutches; and the crutch isn't taken from a cripple until it is no longer needed. It is necessary to evaluate the patient's level of dependence and strike a level just a fraction above it. Thus, we reduce the need without increasing the tension.

One of the most frustrating problems in the care of neurotic patients with somatic complaints is interper-

Miss Parley is on the staff of the psychiatric unit, University Hospital, Saskatoon, Sask.

sonal relations. It is difficult for most nurses to conquer their own feelings regarding such patients. Most of us groaned inwardly when Mrs. Bradley was first assigned to our care — especially before she began to show improvement. Matheney and Topalis, in *The Nurse and the Mental Patient,* have summed this up in a delightful statement: "Psychoneurotic behavior is acceptable only when it is one's own!" We are inclined to think of these patients as "just neurotic," even when we know that they are ill and that their pain is real. It is true that they need firmness and lack of sympathy; but they have a much greater need for acceptance and a feeling of worth.

Possibly three reasons exist for the hospitalization of psychoneurotic patients:

1. Their symptoms limit and interfere with their activities and they are aware of this.
2. The pain or discomfort has driven them to a doctor.
3. Family and friends have wearied of repeated complaints and have begun to reject them.

It is, therefore, of primary importance to accept the patient as she is and to concentrate on her good rather than on her bad qualities. A psychiatrist has said:

> Have a desire to help these patients, or avoid them! They have been rejected and are sensitive to rejection. If you can't accept them sincerely, you can actually do them harm by going near them.

The staff accepted Mrs. Bradley and her complaints. They showed her that she was a worthwhile person by spending extra time with her — a process made easier by the ward system of individual patient assignments. In evaluating the care, several nurses admitted that they had experienced difficulty with her. They found it annoying when she attempted to manipulate them and to criticize when they suggested that her symptoms were psychic in origin. They perhaps forgot that only by establishing rapport *first* can the nurse get away with this heresy.

Conversion Hysteria

Mrs. Reiter, a strikingly attractive silver-haired lady in her late fifties, was admitted to the psychiatric unit complaining of loss of function in both legs together with extreme fatigue. The diagnosis was *conversion hysteria* — wherein unacceptable, unconscious impulses are converted into bodily symptoms. She was demanding, irritable and aristocractic.

This patient was assigned to my care each day. I realized at the beginning that I did not like her and would have to cope with my own feelings before I could help her with hers. We did not get off to a good start: Mrs. Reiter demanded that she use a wheelchair when she went anywhere— even though the doctor had suggested that she should try to walk without it. Having been persuaded to walk to the doctor's office, she suddenly sat down on the floor in front of the nursing station. I urged her to pick herself up and did not offer any assistance. The doctor helped her up and I wondered why he had done so. I then realized that I had forgotten that Mrs. Reiter was sick. I had carried lack of sympathy too far.

I began to understand that in spite of this patient's "queenliness" she was extremely insecure. When she fell she had needed assurance that she would get support. She coldly accepted my explanation that I had only her best interests in mind. We then talked about her community and clubs, and found that we had a mutual friend. This provided a needed link; the patient forgot our differences and talked. I found that by being a good listener I could like and understand her and help to provide the support that she needed.

Mrs. Reiter had a grade eight education but bragged that all her friends had university degrees. She was an active socialite and club woman, and had developed fairly refined tastes. She treated her husband, who was a plain, pleasant, poorly-dressed farmer, with contempt. Any suggestion that she might owe it to him to share some of his interests as she wanted him to share hers, brought an expression of scornful indignation. The patient's symptoms began to disappear after a few days of verbalizing her feelings.

Mrs. Reiter was not in hospital long enough to become involved in group therapy. Her one activity consisted of

doing psychological tests for the research department; this had great appeal for her. Because of her intelligence and interests, intellectual insight came easily. Her doctor discussed with her the realities that she would have to face and then discharged her.

Whether or not she will remain well is difficult to predict. With this type of patient, removal of the symptoms is not the goal. Insight and the maturity to deal with the home situation are the real goals for Mrs. Reiter — and they are difficult ones to achieve.

Volunteer Workers in Mental Health

JESSIE BRIDGES, B.SC.N. *and* SISTER MARY BEATRICE, M.ED.

The pilot project described here serves to indicate the value of the contribution made by volunteers.

History shows that where the needs of human beings in various areas were not being met, pioneers volunteered to provide the necessary help. The achievements in such fields as tuberculosis and poliomyelitis are well-known examples. In the field of mental health, the value and place of volunteer workers are not so widely recognized and accepted.

The volunteers for whom this project was planned were members of the Canadian Mental Health Association, most frequently referred to as CMHA. For better comprehension of the objectives and the structure of this project, it may be helpful to have a bird's eye view of the association. The CMHA was founded by Dr. Clarence Hincks in 1918. A small group of professional and business people formed its nucleus in Eastern Canada. Until 1950, the association was known as the National Committee for Mental Hygiene when its name was changed. The first provincial division was organized in Saskatchewan and at present, every province except Prince Edward Island and Newfoundland has a division of this national body.

The Association has four main objectives. The most important deals with research since this is the weakest feature of Canada's mental health program. The only sizeable private fund for mental health is maintained by CMHA. Total capital is between eight and nine million dollars. If Canada, through governmental support and private appeals, could bring research in mental health to a level comparable with that in other fields of medecine, more rapid progress and more positive solutions would probably be achieved in resolving our greatest health problem.

Another objective is to disseminate information. A prime aim of the Association is to replace incorrect ideas about mental illness with facts. The people who suffer from this type of disorder are open to serious hurt from the public's superficial opinion of mental disturbances. The Association also endeavors to promote social action by means of several programs which attempt to encourage governments to provide modern treatment.

In addition to these objectives, the Association provides some assistance to the mentally ill before, during, and after treatment. Personal help is offered in the form of counselling. The

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Sister M. Beatrice is nursing instructor in social sciences at the St. Joseph's School of Nursing, Victoria; Mrs. Bridges is on the staff of the Greater Victoria Metropolitan Health Service.

sick people are directed to proper sources of treatment. In conjunction with these services, there are two worthwhile projects in the form of a volunteer visiting program, and the provision of White Cross Centres which aim at helping discharged patients to cope with everyday living. The latter provides facilities for socialization and handicrafts.

The Victoria branch of the British Columbia division saw the necessity of providing some basic preparation for volunteer workers. The executive committee asked two nurses to design and conduct a course to help these people to achieve the objectives of the organization in a more realistic way. Convinced that there was room for more and better trained non-professional workers, the two women, one a public health nurse with the public health services, the other a clinical supervisor with teaching experience, accepted the challenge. The central objective of the course was to help the volunteer workers to bring the outside world to the mentally ill. The instructors were of the opinion that man, in the course of his development and maturation, puts down roots into the community and identifies himself with family and also with recreational, occupational, political, and religious groups. The deep-seated effect that this identification produces must be maintained even in the treatment of the mentally ill. The patient forms a relationship with the volunteer worker that is different from his relationships with the hospital staff who are responsible for his day-to-day care. It is expected that the patient-volunteer relationship will do two things: Help the patient to think of himself as a person who is still a member of the community; stimulate him to take an interest in the outside activities from which the very nature of his illness has removed him.

The course was designed to meet local needs. Volunteers were required for the White Cross Centre, a recreational centre with limited rehabilitation facilities. Others were needed to locate boarding homes for patients returning from hospitals, and to establish the patients in these homes. Still others were in demand to visit patients in the psychiatric wards of local institutions, especially those whose homes were outside the city. Selected volunteers were required to work with patients who were still having treatment and were unable to cope with daily living without assistance. More workers were needed to transport patients to keep appointments with doctors and hairdressers; to attend social functions; to utilize the facilities at the White Cross Centre.

The orientation course was conducted weekly and a total of 30 hours was allotted to it. As this was a pilot project, it was not widely advertised. The instructors preferred to limit the enrolment to not more than 30 registrants. Of this number, 28 completed the course and took two tests. One participant was transferred to Toronto where she continued the course by correspondence and the other one, a male member, had to drop out due to his working hours. These 21 women and seven men represented a good cross-section of the community: college students, housewives, business executives, navy personnel, a public health nurse, stenographers, and two deaconesses. A nominal fee of two dollars was charged to cover the cost of notes and postage on films. The group met informally. The methods used in teaching were lectures, films, charts, role-playing, and reports given by the individual participants from a selected bibliography.

In addition to the central objectives, four additional aims were visualized:

1. To help the volunteer workers to understand their role in the Victoria Branch of the CMHA;

2. to assist the volunteer worker to acquire ease and understanding in visiting patients in institutions, in homes or at the White Cross Centre;

3. to acquaint the volunteer worker with the limitations of his responsibilities in the various areas where he might be offering his services;

4. to help the volunteer worker to realize the importance of taking direction from the hospital staff concerning policy and patient needs.

To fulfill these aims, the course content was divided into two parts. The first section was devoted to the relationship of personality develop-

ment to health. An attempt was made to explain the meaning of mental health as it appears at one end of a continuum with mental illness at the other. Consideration was given to the many variations that lie between. Some factors that might lead to less healthy attitudes were presented in graph form and by means of charts. These proved to be useful in depicting normal development and failure to adjust.

Since it is generally accepted that satisfactory interaction and the ability to get along with others are indices of the state of a person's mental health, section two stressed communications and interpersonal relations. The basic needs of all people formed the foundation on which this section was developed: recognition of effort, accomplishment of goals, maintenance of self-esteem, and the acceptance of an individual as he is were some of the means explored in order to meet these needs. Some time was spent in discussing the volunteer's role in public relations. The frequently quoted statement of Abraham Lincoln was the theme of the section on human relations.

> In this and like communities, public sentiment is everything. With public sentiment nothing can fail; without it, nothing can succed. Consequently, he who molds public sentiment goes deeper than he who enacts statutes or pronounces decisions. He makes statutes possible or impossible to be executed.

Attention was given to interaction with the emotionally disturbed. Two psychiatrists conducted conferences on the evolution of the treatment of the mentally ill; the limitations and responsibilities of the volunteers; the attitudes that are essential for helping patients. Several astute observations gathered through years of experience and great understanding of human relations were brought out in these sessions. For example, in regard to giving advice, the class was told that if anyone felt compelled to give advice, the best course of action is "don't." About asking questions, the group was cautioned that even the best questioner makes mistakes. They were advised to be careful in this regard; alert, sympathetic listening was preferable to questioning. Once again, the best way to ask questions is, "don't." Workers were admonished against gossiping about patients. A portion of the Hippocratic oath: "above all, do no harm," was recommended for practice.

As part of their orientation, members were taken on a tour of a psychiatric ward. At this time they met the head nurse and the social worker who explained a day in the life of a patient in that setting. Throughout the entire course emphasis was placed on the fact that an optimal helping relationship is the kind of relationship created by a person who is psychologically mature. The degree to which the volunteer can create relationships that facilitate the growth of others as separate persons is a measure of the growth that he has achieved for himself.

As part of the course, participants had an opportunity for practical application of the theory that was presented in the discussions, role-playing, and movies. They planned and organized a party for the patients in the psychiatric division of a local hospital under the supervision of the psychiatric social worker and the two nurse instructors. The program involved active participation by both the patients and the hosts. A singsong and noncompetitive games provided suitable interaction between the two groups. Lunch was provided by the volunteers and the patients helped to serve and to clean up afterwards. An eavesdropper heard one patient say to another, "To think someone made these pretty sandwiches for us!" The whole assembly was thrilled by the performance of one of the local magicians who gave his time and talent to add to the fun of the party.

To mark the completion of the 30 hours of class attendance, a no-host dinner was held at the White Cross Centre where the volunteer members had an opportunity to meet the executive committee of the Victoria Branch of the CMHA. Both the press and the local T.V. station gave excellent coverage of this event and, in addition, an occasion was provided to acquaint the public with the needs of the mentally ill. Through this publicity several people indicated that they wished to

take a similar course, and become active members in the Canadian Mental Health Association.

The various activities in which the volunteers may become engaged have been outlined previously. Some people will be better suited to perform in specific areas than others. Several tests were made to determine the strengths and weaknesses of these individuals. The first was the registration blank. This was structured to provide information regarding vital statistics, the motivation which prompted the applicants to follow the course, their hobbies and their talents. Two open-book examinations based on the material of the course content were completed by the group. One of the local psychiatrists administered a modified psychological paper and pencil test to determine emotional stability. Finally, the selections committee, composed of two local psychiatrists, one nurse instructor, and a social worker, reviewed the material. The final result was a list of volunteers, indicating when each would be available and in which area each one would be most effective, which was placed at the White Cross Centre. It was understood that coordination of volunteer services and continuing supervision would be necessary to maintain the program at safe and useful levels.

This pilot project was not conducted without its share of criticism and frustration. The occasional remark was made about fostering a group of "amateur psychiatrists." However, most comments of this nature originated from persons who had no knowledge of the course content, its objectives or the backgrounds of the people who had registered for it. Occasionally, films did not arrive on time and last minute substitutions had to be found. Time for hobbies and relaxation had to be sacrificed in order to prepare notes, charts and material for the classes. Despite these minor disturbances, those who participated in the construction and in the execution the project felt that it was well worth the effort.

It would appear that the objectives set in the beginning have been achieved. The volunteers appear to be dispatching their duties with understanding and with a new awareness of the responsibility that it is their privilege to assume. The psychiatric team has indicated that these workers are both needed and accepted. The volunteers themselves have not lost their keenness but have asked for some form of continuing educational program. New groups of interested people are registering to follow similar courses. The nurse instructors feel that they too, have gained something; they have been afforded the opportunity to correlate previous learning and to augment it by further study and research. This has also been an occasion for them to make a contribution to the community.

IN A CAPSULE

LET'S NOT BE TECHNICAL !

We often hear nurses complaining of work they are called upon to do: junior nurses resenting having to empty sputum jugs — a duty which they think should be undertaken by the ward orderly; third-year students and staff nurses desiring only to do "senior" ward work (dressings, injections, doctor's rounds, etc.) and most reluctant to attend to the patient's basic nursing care needs.

What do we understand by nursing? Quite simply, it means the full care of a sick person; it means doing everything in our power to help him to regain full health and return to normal life — not only to wield a syringe and administer drugs. These latter duties are necessary, of course, but could be done quite efficiently by any trained technician. Our work is to bathe the patient when he is too weakened by illness to raise himself; to feed him until strength returns; to attend to all his natural body functions; to comfort him and make life bearable when he despairs and his illness cannot be cured.

Any man or woman who is unable or unwilling to perform all these duties gladly is unfit to be called "nurse;" the presence of this person should not be tolerated in our profession. — KERRANE, T. A. Judging a Good Nurse. *Nursing Mirror*, 116:537, Sept. 20, 1963.

NURSING ATTITUDES STUDIED

A two-year study conducted at a Montreal hospital presents interesting data concerning student nurses' attitudes. The study was motivated by the general feeling of dissatisfaction that exists with present-day nursing school curricula and teaching methods, and the increasingly high student withdrawal rate from such schools.

When student attitudes and achievement were studied for interrelations, a highly significant negative relationship was found. That is, those students who had the highest *attitude* scores i.e., who liked nursing best, also had the *lowest* achievement scores (as rated by their head nurses, instructors, etc.) i.e., were rated as being the poorest in practical aspects of nursing; conversely, those students who disliked nursing most were rated as being best in practical aspects of nursing.

The investigators suggest that the more intelligent students are bored by repetitive work routines, and tend to develop negative attitudes toward nursing. They are, however, able to perform better than the other students, and, consequently, are given higher achievement scores on their practical work.

As long as nursing curricula are service-oriented rather than education-oriented, the situation described will prevail — the average student cannot be expected to develop favorable attitudes toward a discipline in which she is exploited by having to perform repetitive work routines endlessly. Student withdrawals will continue as a result. — Van, George. Nursing Attitudes. *Canadian Hospital*, 40:41, July, 1963.

EXPERIENCE NEEDED

"But how," asks the masculine critic, "can you possibly judge the standard of patient care in only one visit to a hospital ward?" The answer is that it cannot be done by just anyone. An experienced nurse can, however, gain a fairly good idea if she keeps the following points in mind:

In any well-run ward there should be an atmosphere of reasonable calm; nurses should not be running to and fro in a state of hen-like hysteria. Patients should demonstrate a well-cared for look. The women's hair should be tidy, evidence of attention having been paid to it. The state of the patients' finger-nails is a very fair indication. Long, dirty nails on the elderly are evidence of something very wrong. The condition of the bed linen is also indicative and, of course, most revealing of all (but not usually visible) is the state of the bottom sheet. Tops of lockers should be clean and jugs of water covered.

Experience is required to make these judgments. —, *Nursing Times*, 59:976, 1963.

THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

Post-convention Tours

For those who will not have time to take advantage of the European post-convention tour, a small allotment of berths has been obtained on each of the following Canadian National Steamship services, which will be subject to steamers operating out of St. John's at suitable dates following the meeting:

1. A 7-day voyage of 946 miles from St. John's to Cornerbrook on the S. S. *Northern Ranger*. Minimum first-class fare approximately $75.70 one-way.

2. A 6-day voyage of 789 miles from St. John's to Goose Bay, Labrador, on the S. S. *Cabot Strait*. Minimum first-class fare, approximately $63.10 one-way.

3. Day excursion by air to St. Pierre *et* Miquelon and return.

Brochures outlining travel arrangement from home-towns to St. John's and return, as well as the post-convention tours are available from your provincial association and from National Office.

Local Transportation

The nurses of Newfoundland have arranged daily bus transportation for delegates from their hotels to Memorial University. No one need worry about taxis for convention week.

What to Wear

Newfoundland can be on the chilly side in June. Remember to pack a sweater or two, light wool dresses and perhaps a suit. Remember, also, to pack suitable clothing for the boating trips planned, and bring your flat-heeled shoes for Memorial University. We have been asked not to wear high heels in the university and have promised to remind every nurse attending about this. Shoe bags will be provided for your high heeled shoes. If you have no brogues or duty shoes with you, even your bedroom slippers would serve.

Church Services

A mass will be celebrated at The Basilica at 6:15 p.m. Sunday, June 14. This church, built of limestone and Irish granite in the shape of a Latin Cross, holds 8,000 worshippers. It houses rare sculptures and religious symbols, among them Hohan's "Dead Christ" which lies at the foot of the High Altar.

An Anglican service will be held at the Cathedral of St. John The Baptist Sunday evening, June 14 at 6:30 p.m. Here you will find one of the finest examples of ecclesiastical Gothic architecture in North America. Designed by Sir Gilbert Scott, the church was destroyed by fire in 1842 and again in 1892. The present building was restored in 1905. A golden communion service presented by King William IV and other precious religious objects are kept in the Chapter House of the Cathedral.

Members of the United church may attend a 7:00 p.m. service at Gower Street United Church, Sunday evening, June 14. And for those of the Jewish faith, a service will be held at 10:00

p.m. Friday, June 19 at Bethel Synagogue.

The Agnes Campbell Neill Memorial Award

Through an educational award, the members of the Nursing Sisters' Association of Canada proudly honor the memory of the late Matron-in-Chief, Agnes Campbell Neill, O.B.E., R.R.C., L.L.D. during each biennial meeting of the Canadian Nurses' Association. The recipient of this Award for 1964 will be announced during the biennial meeting in St. John's, Newfoundland, June 14-19, 1964.

Applications are now invited for this Award. The following information is for the benefit of those nurses who may wish to apply:

Award

1. The amount of the Award shall be $500.

2. The Award shall be given every two years to a suitable candidate who is planning to further her nursing education through university study and who meets the requirements set up by the Nursing Sisters' Association.

Applicants

1. Applicants for the Award shall be nurses who are registered in a province in Canada.

Preference shall be given to:

a) Former nursing sisters who have served in Her Majesty's forces;

b) Relatives of nursing sisters or veterans;

c) Other veterans who have served in the Allied Forces.

Applications

1. Application forms may be obtained from the Canadian Nurses' Association, 74 Stanley Avenue, Ottawa.

2. The processing of applications will be carried out by the Agnes Campbell Neill Memorial Award Committee with the assistance of the Canadian Nurses' Association.

3. The Canadian Nurses' Association will provide professional advice to the Nursing Sisters' Association or their representatives with regard to qualifications of applicants

4. All applications must be received at the Canadian Nurses' Association headquarters not later than April 15, 1964.

WHO Assignment

Miss WILHELMINA VISSCHER of Ottawa has left to take up a two-year posting with the World Health Organization in Cambodia. In her nursing administration post, Miss Visscher will work closely with the Cambodian nurse leaders and the Ministry of Health.

CARE Mission

Miss CATHERINE LINGER of Hamilton, Ontario, is serving with CARE-MEDICO at Laskkar Gah in Southwestern Afghanistan.

Miss EILEEN NORTON and Miss KATHLEEN ROSS, both of Montreal, will join the MEDICO teams at Lamphat and Kratie, Cambodia.

Miss DIANA SYMONS of Victoria, B.C., has joined MEDICO at Kuala Lipis, Malaya.

ICN News

Miss Mary Patten of Australia has been appointed Assistant Director to the Social and Economic Welfare Division at ICN Headquarters. Miss Patten, who qualified as a nurse at the Melbourne School of Nursing and obtained her midwifery qualification in Scotland at the Simpson Memorial Pavilion, Edinburgh, and the Motherwell Maternity Hospital, took up her appointment January 6, 1964. Miss Patten is the first Australian nurse to be appointed as an executive officer on ICN staff. She brings to her post a wide background in the field of a professional organization and of social and economic welfare for nurses.

ICN Request

Miss DAISY BRIDGES, the former ICN General Secretary, is undertaking the project of writing a history of the International Council of Nurses covering its 65 years of development.

If any individual nurses have in their possession reports, letters or other material which might be relevant to the past history of the ICN, Miss Bridges would be grateful to receive them. Of particular value would be any information relating to the years 1925 to 1936 when ICN headquarters was established in Geneva; and any

correspondence with honorary officers of the ICN during the years 1939-1945.

Please mail to: Miss D. C. Bridges, 60 Burton Court, Chelsea, London, S.W.3, England.

ALL MATERIAL WILL BE RETURNED.

In Memoriam

Barbara Joyce (Fry) Ayre (Royal Jubilee Hospital, Victoria '53) died on August 7, 1963 in Belleville, Ont.

* * *

Hilda Gladys Barron (St. Joseph's Hospital, Victoria '32) died in Chilliwack, B.C. on September 27, 1963 after a long illness. She had engaged in private nursing.

* * *

Josephine Betz (Highland View Hospital, Amherst, N.S. '24) died early in October in Sackville, N.B. She was a member of the first graduating class of the hospital and served for 20 years as supervisor of the operating room, then as instructor of nurses until the hospital discontinued its school of nursing. Miss Betz retired from active nursing in 1960.

* * *

Mary Gertrude Blatz (Misericordia General Hospital, Winnipeg '31) died in Ninette, Man. on September 27, 1963. She was the operating room supervisor of the Manitoba Sanatorium, Ninette at the time of her death.

* * *

The death of the following graduates of the Winnipeg General Hospital is recorded with regret: **Beata Mary Bowering** '23; **May MacGregor (Guthrie) Drew** '27; **Margaret Roberta McClung** '17.

* * *

Constance Brosseau (St. Vincent de Paul Hospital, Sherbrooke '60) died as the result of an accident on October 18, 1963. She was 24 years of age.

* * *

The alumnae association of The Montreal General Hospital records with regret the death of the following graduates: **Frances E. W. Coleman** '29; **Jean M. (Picken) Danforth** '39; **Eleanor (White) Griffiths** '06.

* * *

The alumnae association of the Royal Victoria Hospital, Montreal records with regret the death of the following graduates: **Helen M. (Sally Eberle) Cranston** '29 on November 7, 1963 and **Beatrice (Watson) Downs** '20 in August, 1963.

* * *

Ivy Beatrice Davy (Rotherham Hospital, Yorkshire, England '09) died in Vancouver in September, 1963 following a car accident.

* * *

The alumnae association of the Portage La Prairie General Hospital records with regret the death of the following graduates: **Rosalind (Crossland) Doak** '17 on October 23, 1963 and **Amy H. (Flewelling) Flook** '30 on September 12, 1963.

* * *

Pearl G. (Tinney) Fallis (Hamilton General Hospital '19) died on August 29, 1963.

* * *

Celia (Fahlman) Friesen (Regina Grey Nuns' Hospital '30) died on November 4, 1963 in Mortlack, Sask.

* * *

Kathleen M. (Briggs) Gies (St. Michael's Hospital, Toronto '25) died on November 9, 1963 in Toronto.

* * *

Thelma Dorothea Green (Toronto General Hospital '22) died on October 18, 1963. In 1953 she was appointed civil defence nursing consultant for Ontario after extensive experience in the industrial health field.

* * *

Mabel Elizabeth (Hendricks) Holsey (Belleville General Hospital, Ont. '39) died on July 31, 1963. She had engaged in institutional nursing.

* * *

Patricia Mary Johnson (Soldier's Memorial Hospital, Orillia '57) died in June 1963.

* * *

Sister Mary Ignatia (St. Joseph's Hospital, Victoria '32), a staff member of St. Mary's Hospital, Dawson, Yukon Territories, died late in 1963.

Nursing Profiles

(Paul Horsdal Ltd., Ottawa)

M. CHRISTINE MACARTHUR

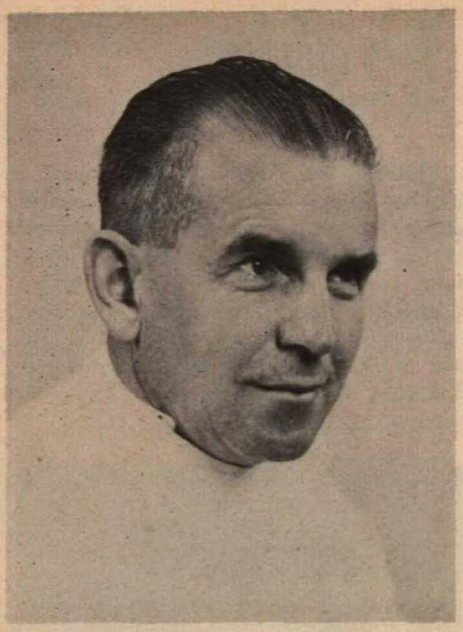
M. Christine MacArthur, educational director of the Victorian Order of Nurses for Canada for the past eight years, has been appointed assistant director in chief. She replaces **M. Elizabeth Reed** who recently retired from the Order. Miss MacArthur, a graduate of Toronto Western Hospital, joined the VON after obtaining her certificate in public health nursing from the University of Toronto. Her first posting took her to Fredericton, N.B. for a three-year term as staff nurse. She returned to Ontario and the position of nurse-in-charge of the Huntsville unit and later joined the Sudbury branch in the same capacity. A year off for study at Teachers College, Columbia University completed requirements for a bachelor of science degree in supervision in public health nursing. Miss MacArthur returned to become assistant superintendent of the Winnipeg Branch. In 1952 she came to the Ottawa headquarters as a national supervisor, relinquishing this post to become educational director in 1955. In 1958 she went to the New York Institute of Physical Medicine and Rehabilitation for further study, this time in rehabilitation nursing techniques.

Through the years she has become a familiar figure to nurses across the country, either through her various VON capacities or the offices held in professional associations. A member of the Finance Committee, Canadian Nurses' Foundation, Miss MacArthur is a former president of the MARN and of District 8, RNAO. Congratulations and good wishes are extended to her as she takes up her new duties.

MARGARET INGLIS

Margaret Inglis has joined the staff of the Nova Scotia Hospital Insurance Commission as a nursing counsellor. A graduate of Children's Hospital, Halifax, she studied psychiatric nursing at the Nova Scotia Hospital, Dartmouth and later joined the staff of Toronto Sick Children's Hospital as a general duty nurse, moving up to the position of evening surgical supervisor. She is a former staff member of Montreal Children's Hospital where she worked as a general duty nurse and as a member of the teaching department.

Miss Inglis obtained a diploma in teaching in schools of nursing from Dalhousie University in 1960 and in 1963 completed requirements for her Bachelor of Nursing degree from McGill University.



HARRY MCDONALD

graduate of the Royal Hospital, Montrose and the Stracathro School of Nursing, Brechin, Angus, both in Scotland, Mr. McDonald has had special preparation in mental nursing and since coming to Canada has obtained his diploma in nursing service administration from the University of Western Ontario, London. Before accepting his present position, he was on the staff of Westminster Hospital, London, Ont. where he served successively as staff nurse, head nurse, nursing supervisor of orderlies and nursing supervisor in psychiatry. During World War II he served as an aircrew member with the Royal Air Force in the European area. Mr. McDonald is a former member of the RNAO Male Nurses' Committee and the Nursing Service Committee. He also served on the membership committee and as treasurer of the Middlesex Chapter, London.

Alice Ruth Thomas MacKinnon has been appointed associate director of nursing education, Foothills Provincial General Hospital, Calgary. A graduate of the University of Alberta Hospital, Miss MacKinnon received her B.Sc. from U. of A. and in 1963 completed requirements for her Master's degree in nursing from the University of Washington, Seattle. Her past experience has included duty as a head nurse, supervisor and staff nurse. In 1957 she became principal of the School for Nursing Aides, Edmonton, the position she relinquished in order to assume her present duties.

Name in the News

Mona Wilson, O.B.E., M.B.E., Charlottetown, P.E.I. has been awarded the Florence Nightingale medal for her nursing work in Canada and overseas, 1918-61. She is the ninth Canadian nurse to receive the medal since its establishment in 1912. Miss Wilson was assistant commissioner of the Canadian Red Cross Society, Newfoundland, 1940-45 and previously, had served for several years with the Red Cross in P.E.I. before becoming director of the public health nursing division in that province.

GRAND PRIZE WINNERS

The "IT" Micro White and White Scuff Shine contest is completed and the manufacturer informs us that interest shown by the nursing profession was high all across Canada. As readers know, 40 ward-set prizes a month, comprising two ball-point pens and a thermometer, were awarded in April, May, June, July and August, 1963. The 16 grand prizes included a Gruen precision nurses' watch, two ball-point pens and a clinical thermometer in an attractive jewellery box.

Grand prizes were won by: Mrs. C. A. Butler, St. John's, Newfoundland. Mrs. Lillian Torttila, Sault Ste. Marie, Ontario. Miss Eve Aquino, Sudbury, Ontario. Mrs. W. Birnie, Fort Erie. Ontario. Miss Beverly J. Statia, Toronto, Ontario. Mrs. Elaine Kuenzig, Toronto, Ontario. Miss Barbara Bycroft, Montreal, Quebec. Miss Evelyn Cooper, Winnipeg, Manitoba. Mrs. K. Coleman, Vancouver, British Columbia. Mrs. D. G. McKay, Wellington, British Columbia. Mrs. Edith Peart, Guysborough, Nova Scotia. Mrs. Eber Ingraham, Woodstock, New Brunswick. Miss Reina Gagni, Granby, Quebec. Miss Marguerite Millette, Montreal, Quebec. Miss Frances Whittle, Lennoxville, Quebec. Miss Alice Levesque, Ste Anne de Bellevue, Quebec.

The company thanks all those who entered the contest and hopes they will all continue to use "IT" White products — ideal for nurses' shoes.

AS THE STAFF NURSE SEES IT...

One hundred and fifty practitioners of nursing discuss the profession and its modus operandi.

"We want more time to give the patient personal nursing care." This recurring theme dominated the recent Conference on Nursing for Staff Nurses held at the Westbury Hotel in Toronto.

The Conference, conducted by the Registered Nurses' Association of Ontario, was attended by staff members from hospital nursing, official and voluntary public health agencies, private nursing, doctors' offices and occupational health services. Despite this diversity in work setting, the nurses shared a common function — providing direct care to patients.

Objective of Conference

The president of the RNAO, Miss Jenny M. Weir, welcomed the assembled nurses. She pointed out that nursing has unanimity of purpose — to provide good nursing care for the public. Although unanimity of methods is neither possible nor desirable, there must be substantial agreement on the principles involved in providing this care. "Nurses all over the province are looking at principles underlying nursing," Miss Weir stated. "This week, we will ask the same of you."

Miss Dorothy Hardwick, convener of the Planning Committee (a committee comprised of nurses from various areas of nursing) identified the main objective of the conference:

To provide an opportunity for staff nurses, as members of the health team, to discuss ways and means for enhancing personal satisfaction and its influence on patient care.

What a Nurse Should Be and Do

This was the topic discussed the first day with Mrs. Lydia E. Hall, Director, Loeb Centre for Nursing and Rehabilitation, Montefiore Hospital, New York, as guest speaker. A dynamic personality, with definite, sometimes revolutionary ideas, Mrs. Hall set the tone for subsequent sessions as she presented her concept of nursing as it *should* be.

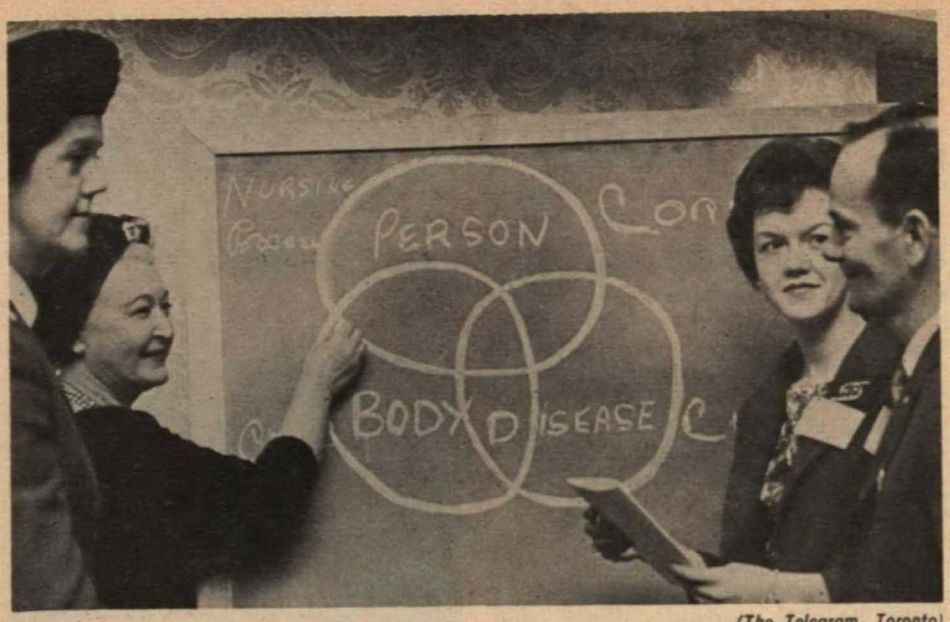
A group in action

One criterion of a profession is that it has a body of knowledge, exclusive to itself, which can be learned and passed on to others. Nursing meets this test of a profession since *the nurturing aspect of care is exclusively ours.* Too often the *caring* aspect is delegated to less well-prepared persons while the registered nurse concentrates on the *curing* aspect.

Mrs. Hall's address follows this report.

Group Discussions

Throughout the five-day conference, a considerable amount of time was spent in group discussion. Each of the thirteen groups chose a recorder whose function was to note the main points made by her group, organize them for use by the work group, and prepare them for use by the whole conference.



(The Telegram, Toronto)

Mrs. LYDIA E. HALL, *discusses the nurse-patient role with* Miss DOROTHY HARDWICK, *convener of the conference, F/O* MARGARET MERCER, *Canadian Forces Medical Service, and* Mr. RICHARD PALMER, *a nurse at Sudbury Memorial Hospital.*

Following Mrs. Hall's presentation, the groups assembled to prepare questions and comments for the afternoon session.

Providing Personal Care

Question: How can the nurse find *time* to give personal care to her patients?

Answer: Mrs. Hall replied to this by stressing that care of the *person* of the patient should be given a "piece at a time" — not as a single procedure. The nurse can incorporate this into everything she does for the patient — bathing, feeding, etc.

Q. How can one give the patient emotional support without encouraging him to become too dependent?

A. Patients are either very dependent or very independent. We should let patients *be* themselves while giving them the opportunity to *see* themselves and thus become more independent.

Q. How does a nurse answer a patient who asks a question such as: "Do I have cancer?"

A. Mrs. Hall's response was: "You want to know whether or not you have cancer?" Use this not as a technique, but to explore *what the patient really wants to know*.

Q. How does nursing become professional?

A. We make it professional by our own actions, by our teaching, and by our interpretation of selves to patients. doctors and the general public.

What Kind of Nursing Do we Want to Do?

The group members discussed this topic throughout the morning of the second day of the conference. In the afternoon, a panel, chaired by Mrs. Caroline Tosh and consisting of several recorders, presented the group reports. Members of the audience contributed extensively to this session. Many points related to the status of the nurse and to job satisfaction as well as to actual nursing care.

The panel expressed the views that:

1. The registered nurse should be able to spend more time with the patient. Less of her time should be consumed by non-nursing duties and steps should be taken to prevent her from becoming a "practical doctor." More nurses should be assigned to cover the evening and night shifts.

2. The status and function of the registered nursing assistant should be more clearly defined so that her responsibilities and limitations are better understood.

3. There is too much emphasis on routine and too little opportunity for the staff nurse to exercise individual judgment. The head nurse should know her staff so that she can assess the efficiency of each practitioner and thus assign fewer patients to the person who works slowly yet thoroughly.

4. The staff nurse should have an opportunity to confer with other members of the health team regarding patient care. She should not be expected to *blindly* follow "doctor's orders."

5. Staff nurses should have more opportunities to voice *their* opinions about factors affecting patient care. Employing agencies should encourage this by having regular staff meetings and inservice educational programs. Opinions expressed by staff nurses should be carefully considered — not disregarded, as is frequently the case.

6. The shortage of staff nurses is due in part to inadequate financial remuneration. The staff nurse is considered to be essential, yet is found at the *bottom* of the salary scale. Why was the decision made to dismiss the idea of "withdrawal of services" as a bargaining tool?

Considerable discussion followed each presentation. Additional comments concerning the salary of the staff nurse were made at a later session.

What Do They Think?

Guest speaker, Dr. Oswald Hall, Professor of Sociology, University of Toronto, focussed attention on the status of nursing as a profession in our society.

When attempting to determine the status accorded to nursing by society, it is necessary to examine the attitudes of various categories of people in society, rather than taking an over-all view.

Studies have shown that persons who would be classed as "unskilled workers," hold nursing in high esteem whereas those who would be classed as "professional" — such as doctors — rate nursing low.

A study made in Kansas City revealed that 90 per cent of those in the semi-professional or professional occupations could see a difference between the registered nurse and the nursing assistant while only 33 per cent of those in unskilled occupations were aware of a difference.

DR. HALL *and* MISS HARDWICK

Respondents of this study viewed the R. N. as one who had more authority, who was able to perform more "technical" tasks and who supervised the nursing assistant's work. They recognized her as having more education and being more professional. Some expressed the opinion that the nursing assistant was "sweeter" and "more considerate" of the patient. Although these differences were observed, there was evidence of considerable confusion regarding the two roles. Thus the status of the registered nurse seems to be ambiguous in the eyes of the public.

Dr. Hall was asked if the status of nurses would rise if the salary was higher. He pointed out that money is not a guarantee of status, e.g. a gambler has more money but less status than a teacher in the community. "Nurses are valued," he stated, "because of the things they do — often things others would not or could not do." He added that he was not, however, opposed to higher remuneration for nurses.

RNAO, College of Nursing, and OHSC

Group discussion gave rise to questions concerning these institutions. As a result of this, a panel, consisting of Miss Laura Barr, executive secretary of the RNAO, Miss Jean C. Watt, director of the College of Nurses of Ontario and Miss Louise Jamieson, nursing consultant with the Ontario Hospital Services Commission, helped to clarify the issues.

Q. Why is membership in the RNAO not compulsory?

A. RNAO asked for this, but the principle of compulsory membership in a professional organization was not supported by the provincial government. Our strength really lies in the fact that the Association *is* voluntary. Compulsory membership would provide more members, it is true, but it would not necessarily provide persons who were active and interested in the Association.

Q. What does the $20 fee for active RNAO membership cover?

A. We are all responsible for the breadth of our profession. The Association is the vehicle through which we can do things for our profession. The RNAO:

1. Supports active recruitment programs throughout the province;
2. promotes good public relations for nursing by paying for the services of a professional public relations counsel;
3. sponsors income protection program for members;
4. provides membership in the CNA and ICN;
5. provides consultant services to interpret RNAO personnel policies to employers;
6. provides legal consultation for members requesting it;
7. supports loan fund for members enrolled in a university course;
8. holds conferences and workshops throughout the province.

Q. What are the functions of the College of Nurses of Ontario?

A. The College acts as the body that sets *minimum* standards in the following areas:

1. Admission requirements to a school of nursing
2. curriculum
3. inspection of schools of nursing
4. examinations
5. registration of nurses and issuing of certificates annually
6. discipline.

Q. Why do qualifications for admission and registration vary from province to province?

A. The BNA Act granted control of health and education to the provinces. The final authority thus lies with each provincial legislative assembly.

Q. Why can't RNAO personnel policies — particularly with regard to remuneration — be enforced?

A. At the annual RNAO meeting in 1958, three methods of negotiating with employers were considered. The members of the Association voted at that time to support a policy of voluntary negotiation for five years. During this period, the RNAO has helped to interpret its policies to employing agencies.

In 1963 the Board of Directors was asked to study collective bargaining. The results of this study, undertaken by Dr. John Crispo, will now be submitted to the RNAO Committee on Socio-Economic Welfare.

We are leaning toward compulsory legislation. Whatever the decision, it must be the "best thing for the most" — that is, for the 45,000 nurses in Ontario.

Q. Does the Ontario Hospital Services Commission control salaries, and the ratio of professional to non-professionnal personnel?

A. Yes, the Commission allocates the maximum amount to be devoted to salaries; each hospital, in turn, sets salaries within this budget. There is an attempt to discourage competition among hospitals in any given area.

There is no set ratio between professional and non-professional staff. This depends on the availability of personnel.

Who Should Provide Bedside Care?

Concern was expressed by several groups that much of the direct bedside care — the nurturing aspect — was now being given by the registered nursing assistant. Earlier in the week, Dr. Hall had stated his theory of how and why certain tasks are delegated from one group to another:

Each occupational group has its "clean work and dirty work" — things its members like to do and things they despise. There is a continual change of tasks that could be called "bedpan" tasks — functions that are considered to be beneath the occupation's dignity.

What *was* once considered nursing has gone to other persons. Nurses, in turn, have assumed tasks from the doctor.

Some staff nurses at the conference believed that it did not matter *who* gave the nursing care, provided it was of a high quality; others stated that it *does* matter who provides bedside care. There seemed to be general agreement that if the nursing assistant *is* taking over many of the registered nurses' functions, it is because the R.N. is letting her.

Why a Shortage of Staff Nurses

Remuneration, it was agreed, was one reason for the present shortage. Other conditions present in the work situation were also responsible for job dissatisfaction and for nurses leaving staff positions. These included: frequent change of shift with little if any differential in salary; insufficient advance knowledge about rotation plans; too few week-ends off duty; lack of opportunities to express opinions concerning patient care, personnel policies, etc.

It was felt that more men should be encouraged to enter the profession. Mr. Richard Palmer, the only male nurse present at the conference, agreed with this. He pointed out that much of the controversy centred around whether or not the male nurse should care for women patients. Mr. Palmer received applause and laughter when he stated "Contrary to popular belief, the male nurses have no desire to nurse female patients!"

The shortage of nurses could be relieved if the services of married nurses were utilized to a greater extent. It was suggested that some form of day nursery care in the community would enable more mothers to return.

The Patient as an Individual

How can we make the patient feel like an individual? Various suggestions were offered to help achieve this:

1. Always call the patient by name;
2. introduce yourself to patient and explain various hospital routines, e.g. visiting hours, etc.;
3. give the patient an opportunity to speak to his physician *privately;*
4. help interpret his questions to the doctor;
5. explain various procedures before they are carried out;
6. be present to support the patient when he needs this.

Conference Evaluation

An evaluation was completed by each group on the final day of the conference.

Remarks indicated that the staff nurses had found the conference stimulating and of value. The majority felt that more conferences of this type should be held — at least once a year.

Comment

It is regrettable that more staff nurses could not have been present in order to participate. It is interesting to note that several nurses attended on their own time and money. This observer finds it difficult to understand why more employing agencies did not encourage their staff nurses to attend. Perhaps it is time for nurses themselves to interpret to administration the value of such conferences in helping the profession to plan and improve patient care.

V.A.L.

HOW TRUE!

It seems that one speaker at the annual meeting of the British Columbia Medical Association had difficulty with his visual aids. *C.M.A.J.* reports: "Unfortunately the behavior of the sound track (during the showing of a color film) illustrated again the universal validity of Murphy's law."

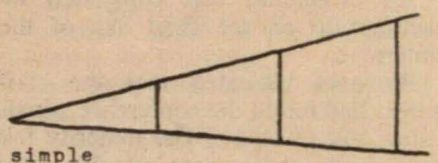
We don't know who Murphy is, but apparently his law states: *"If anything can possibly go wrong, it will."*

Nursing - What is it?

LYDIA E. HALL, M.A.

Physicians do not have practical doctors. . . . They don't need them . . . they have nurses!

Reading and talking about nursing bring out many views of what it is. One view sees the nurse as a Jack or Jill of all "trades;" another view gives the idea that nursing is a line or wedge of functions, ranging from the simple to the complex.



As one explores this latter idea further, it becomes increasingly easy to confuse functions with tasks and activities. A simple *function* is one in which a few factors are taken into consideration before making a nursing judgment of what to do. With this picturization of nursing, the "functions," "tasks," "activities," are divided among nursing personnel, simply or complexly educated, with the highest educated leading the nursing team. This is a logical organization of services if one can go along with this "wedge picturization." This concept reveals the assumption that nursing is vocational in nature since the main emphasis is on the *work to be done* and how this may be parceled among a hierarchy of workers. One can hold no quarrel with this if organized nursing and the public are happy with vocational nursing. However, close inspection of this idea shows an inconsistency with the fact that *there is nothing simple about patients who are complex human beings, or a nurse who is also complex* and who finds herself involved in the complexities of disease and health processes in a complex helping relationship.

One may draw a different picture to show nursing if the conviction is held that it is a professional process. To differentiate the process of nursing from those of other professions, one can visualize three overriding circles, each denoting one aspect of the process as related to the patient, to the supporting sciences and the underlying philosophical dynamics.

The Care

One of these aspects belongs to nursing alone; two are shared with other disciplines. The first, the exclusive aspect of nursing, is the *nurturing* one. This provides the opportunity for closeness. It necessitates seeing the process as essentially that of an interpersonal relationship. This close personal process takes in the intimate bodily care of patients: bathing, feeding, toileting, dressing, undressing, positioning and moving. Only the mother or mothering ones in the community involve themselves in this process. It is the nurse who is looked upon as the expert, the teacher of mothers in classes and in individual conferences.

The nurse who utilizes the mothering of nurturing without mistaking herself for the mother is on her way to professional practice. Patients may confuse her with "mother," but *she* must remain clear as to who she is, if

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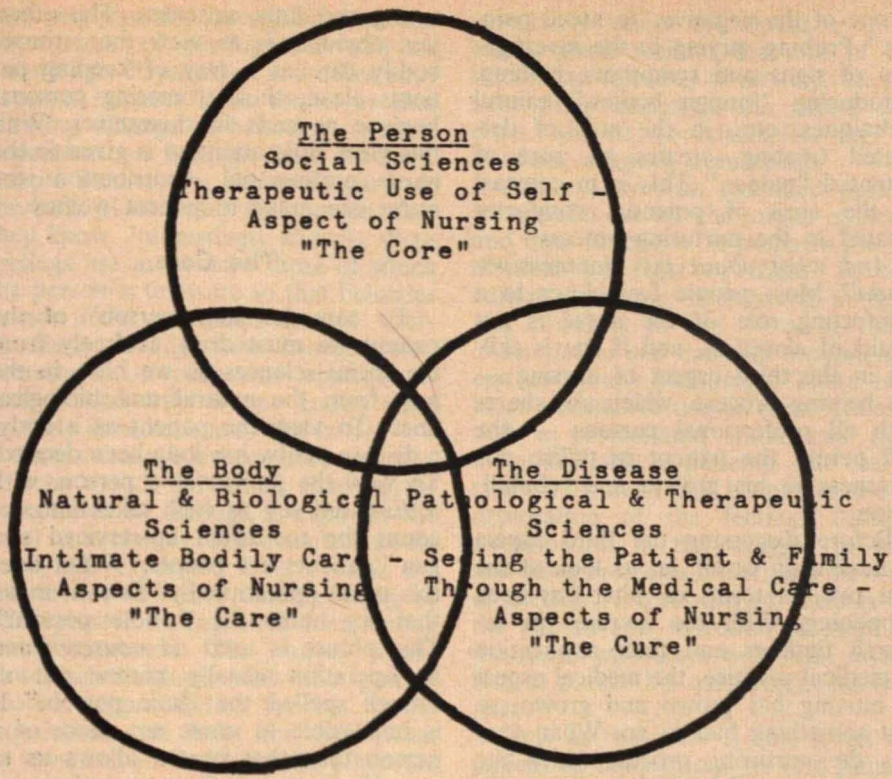
Mrs. Hall is Director of the Loeb Centre for Nursing and Rehabilitation, Montefiore Hospital, New York. She presented this address at the RNAO Conference for Staff Nurses in Toronto in December 1963.

Originally published in the *Virginia Nurse Quarterly*, this article was edited and revised by the author prior to presentation.



she is to be helpful. Since she, too, is a human being, she may, without insight into the problem, confuse the patient, let us say, with "father" — if the patient is a man. If neither the patient nor the nurse is clear, it seems that this nurse is the "mother of her father" — as impossible and unnatural a relationship as one can imagine!

If the interpersonal relationship starts off on this footing, it becomes an illusory figure phantasy rather than a productive reality. It behooves the nurse to know who she is. Nursing curricula must provide experiences which can help her reach this state, so that she is free to accept the patient whoever and wherever he is, and free to use her nursing skills in helping him to clarify "who he is." This exclusive nurturing-aspect of nursing involves the laying on of hands with *comfort* of the patient as the main interest, and, if understood, as the main result.

The Cure

The second aspect of the nursing process is shared with the medical profession. One way of looking at the medical aspect of nursing is to see the nurse as one who assists the doctor who, in turn, is responsible for the medical care, that is who makes an accurate diagnosis, prescribes the therapy and evaluates the progress of the patient. If seen this way, it follows that the medical profession delegates some medical "tasks," "activities," "functions," to the nursing profession. "Delegation" may be the incorrect term for this, since the nursing profession rarely participates in the planning. The physicians, hard pressed and busy, just keep adding to the list of nursing functions, and nurses accept the additional responsibility without question.

Another way to view this aspect of nursing is to see the nurse as one who helps the patient through his medical, surgical, and rehabilitative care. Does she help the patient or the physician? Actually, she helps both, but the direction and quality of help is changed as her view of this aspect changes. In the medical, as in the nurturing aspect, the nurse *lays hands* on the patient. However, the main interest changes from one of the positive "to comfort,"

to one of the negative "to avoid paining." Probing, prying in the investigation of signs and symptoms, jabbing, introducing "foreign bodies," painful techniques, etc., in the area of delegated treating, creates an aura of potential "painer." This is in contrast to the aura of potential comforter created in the nurturing process.

And what about the closeness-potential? Most people feel closer to a comforting role. If the nurse is not afraid of closeness, and if she is skilled in the third aspect of nursing — the helping process, which she shares with all professional persons — she will permit the patient to utilize this closeness in his growth and rehabilitation.

Before discussing the third aspect of nursing in detail, let us look at the first two, in terms of what *has* been happening. With the increase in research findings and their application to medical practice, the medical aspect of nursing has grown and grown, so that something had to go. What went was the nurturing process which the nurse in turn delegated to less well-prepared persons, thereby giving up more and more comforting in favor of more and more "paining."

Just as nursing is faced with shortages of nurses, so medicine is faced with shortages of physicians. Interestingly enough, physicians do not have practical doctors. *They don't need them . . . they have nurses.* Interesting, too, is the fact that most nurses show by their delegation of nurturing to others, that they prefer being second-class doctors to being first-class nurses. This is the prerogative of any nurse. If she feels better in this role, why not?

One good reason "why not" for more and more nurses, is that patients receive from professional nursing second-class doctoring; and from practical nurses, second-class nursing. Some nurses would like the public to get first-class nursing. Seeing the patients through their medical care without giving up nurturing will keep the unique opportunity that personal closeness provides to further patients' growth and rehabilitation. This opportunity goes by the board in two ways. One, the obvious, consists of no nurturing and little closeness. The other, less obvious, is to view the intimate bodily care as a way of keeping patients clean, thus promoting personal hygiene as ends in themselves. With this view, little attention is given to the most professional contribution the nurse can make to patient welfare.

The Core

To care for the "person" of the patient we must draw as freely from the social sciences as we have in the past from the natural and biological ones. To view the patient as a body, a disease entity, has long been decried. To view the patient as a person, with a *dis*-eased self as well, takes into account the too often lip-serviced slogan "patients are people." What does this mean operationally? Does it mean that we nurse the "whole person?" This phrase is used *ad nauseam* and in operation usually comes out as though spelled the "hole person." It is impossible to nurse any more of a person than that person allows us to see. If we permit him to utilize our freely offered closeness, he will not only let us see more of him, but he will allow *himself* to see "more of him" so that he may, with excellent professional nursing, emerge as a "whole person" — in which case he won't be ill and, according to some schools of thought, will stay well. In addition, in the process of exploring with such a nurse — who he is, where he is, where he wants to go and will he take or refuse help in getting there — the patient will make rapid progress toward recovery and rehabilitation.

For the nurse to use self therapeutically, she must have help through nursing education to learn who she is so that her own concerns will not interfere with the patient's exploration of *his* concerns. Besides this, her learning experiences through the media of the social sciences must facilitate the development of interpersonal skills that permit the patient *to be* and, in being, to participate in facing, solving and preventing health problems.

Recognizing Feelings

To work with the patient as a per-

son requires the recognition of the importance of *feelings* as well as knowledge. Psychology and other educational sciences have shown us that learning (change of behavior) is more dependent on feelings than on facts. People behave, for the most part, on the basis of how they feel, not on what they know. Interestingly enough, these feelings are most often those of which the person is unaware so that behavior is not under conscious control. Only as these feelings are brought into awareness, is conscious control affected. And only as one knows what he feels does he know who he is.

Our culture has been more conducive to the denial rather than to the acceptance of feelings, except for the most neutral ones. These neutral, polite ones, are expressed freely; since the self is not so easily denied, many of the repressed feelings lie hidden among those expressed. The nurse, whose close relationships with the patient provide opportunities for his verbal expression, can help him hear what he says and so find himself. When the nurse cuts the patient off from such expression and exploration because of her own lack of self-understanding, he cannot use the relationship as a productive learning experience. If the nurse is a teacher, she will concern herself with the facilitation of the patient's verbal expressions and will *reflect* these so that the patient can hear what he says. Through this process, he will come to grips with himself and his problems — in which case, he will learn rapidly, that is he will change his behavior from sickness to "wellness."

From psychiatry, we learn that people can do three things with their feelings: Express them verbally, thus learning to know self as well as to grow and develop toward emotional maturity; repress verbal expression, in which case, the body communicates the feelings through sickness and *dis*-ease; become psychotic. The greatest feelings of *dis*-ease are those of anxiety during which the person feels threatened, but cannot identify the threat. Only as he is helped to identify it correctly, will he be able to deal with it realistically. He can manage better in fear where the threat is labeled than in anxiety where the threat is unlabeled. Small wonder that out of the discomfort (disease) of anxiety, the patient often mislabels the threat and deals with it unrealistically, e.g. in phobias, sickness, even crime.

Anxiety, over an extended period, is stressful to all the organ systems and their functions. It prepares the individual for fight or flight. In our culture, however, it is brutal to fight and cowardly to flee — *so we stew in our juices and cook up malfunction and eventually pathology*. There is a more productive use of these "juices" that a professional nurse can help make available to patients. The energy created by them can be put to use in exploration of the feelings through participation in the struggle to face and solve problems underlying the state of anxiety. Expression of feelings by the patient and reflection of these by the nurse who stays with him, invites him to pursue his concerns at his own pace.

Only as the nurse is able to let the patient be himself, can he find himself and his way out of the difficulty. Accepting, non-judgmental nursing thus provides the emotional environment he needs to take this kind of a look; through looking, he sees and understands. As he learns more of "who he is," he becomes more self-accepting. He learns to love "who he is" and to the degree that he accomplishes this, he learns to love others as himself — one of the main characteristics of the emotionally mature individual.

The nurse who knows self, by the same token can love and trust the patient enough to work *with* him professionally, rather than *for* him technically, or *at* him vocationally. Her goals cease being tied up with "where can I throw my 'nursing stuff' around;" or "how can I explain my 'nursing stuff' to get the patient to do what we want him to;" or "how can I understand my patient so that I can 'handle' him better." Instead her goals are linked up with "what is the problem?" and "how can I help the patient understand himself?" as he participates in problem facing and solving.

In this way, the nurse recognizes that the power to heal lies in the patient and not in her. She takes satis-

faction and pride in her ability to help him tap this source of power in his continuous growth and development. She becomes comfortable working co-operatively with members of other professions, as she meshes her contributions with theirs in a concerted program of care and rehabilitation.

About Books

Outline of Human Reproduction by Ian MacGillivary, M.D. 100 pages. E. & S. Livingstone Ltd., Edinburgh and London. 1963.

Although written as a "simple outline of obstetrics and gynecology for the beginner, either student nurse, pupil midwife, or medical students," this book would seem to us to be better suited to the needs of the nursing assistant group.

The author writes clearly and concisely, without including too much detail. Diagrams throughout are good.

Basic Facts of Pharmacology by Stewart M. Brooks, M.S. 354 pages. Canada: McAinsh and Co. Ltd., 1835 Yonge St., Toronto. U.S.: W. B. Saunders Company, Philadelphia. Ed. 2. 1963.
Reviewed by E. Hazel Hull, Assistant Coordinator, St. Paul's Hospital, Vancouver, B.C.

The author's implied aim appears to be the deletion of a mass of detail concerning pharmacology for nurses. A new approach to classification and organization has been used: In the first sections of the book, drugs are grouped and discussed according to their pharmacological action or physiological status, while in the latter sections they have been classified according to clinical use. Stress has been placed on vitamins, hormones and electrolytes because, as the author states, "of their vital value to all segments of medical therapeutics."

The book is characterized by clear and generally concise facts concerning drugs. Free use has been made of diagrams, appropriate tables and chemical formulae. Drugs are discussed in the usual groups, but with a representative example, followed by a table of similar drugs and common dosages.

There is an extensive, well-written and easily understood section on the rationale of intravenous therapy.

Toxicology is discussed in a very practical, sufficiently comprehensive manner, despite the dearth of symptoms and details of appropriate nursing care. The author has certainly achieved his objective by "removing the trees to enable the student to perceive the forest."

While considerable emphasis is placed on principles and while there are implications that the student should be stimulated to assume responsibility for further study and investigation, the concise statement and general tone of the discussions might end to dampen incentive through an impression that the content represents the beginning and end of pharmacology for nurses.

This book could serve as a useful text of a very basic course in pharmacology, supplemented by more comprehensive teaching either as a separate subject, or preferably, integrated in medical-surgical nursing.

Nursing the Mentally Subnormal by Charles H. Hallas, S.R.N. 216 pages. John Wright & Sons Ltd., Bristol. 1962.
Reviewed by Miss E. J. Pittuck, Director of Nursing, Ontario Hospital School, Orillia, Ont.

This is a comprehensive presentation of the care of the mentally subnormal. The terminology is somewhat different. However, the principles of nursing care are basically the same as in Canada.

It is a suitable textbook for all ward staff and anyone interested in the care of the subnormal individual.

Normal and Therapeutic Nutrition by Fairfax T. Proudfit and Corine H. Robinson. 858 pages. Ed. 12. Collier Macmillan Canada Ltd., 132 Water St., Galt, Ont.
Reviewed by Frances Ellison, Instructor, Sydney City Hospital, Sydney, N.S.

This text is written primarily for nursing and dietetic students to acquaint them with their role in promoting health through

good nutrition. The influence of research, of advances in food science, and the effect of human behavior as a factor in the acceptance of food is reflected throughout.

The book is divided into three sections. The first includes principles and their application in normal nutrition, the characteristics, functions, metabolism, food sources and daily allowances of the various food nutrients. Special nutritional needs during pregnancy, in infants, children, teenagers and older persons are considered in detail.

The section on therapeutic nutrition emphasizes the effect of illness on the acceptance of food and the rehabilitation of the patient. Diet therapy is developed as a modification of the normal diet. The recipes, and the appendix in the final section, including height and weight tables and the nutritive values of food, would be useful in the clinical field.

The content is well-selected, well-organized, interesting to read. Illustrations, charts and diagrams are excellent. The problems for review at the end of each chapter would be most helpful to instructor and student. A very extensive list of references adds to the general usefulness.

Pharmacology for Practical Nurses by Sister Suzanne Marie, S.S.M., B.S., R.Ph. 164 pages. Canada: McAinsh and Co. Ltd., 1853 Yonge St., Toronto. 1963.

Reviewed by Mrs. Laura Khairat, director, Central School for Practical Nurses, Winnipeg 10.

In the preface the author states her purpose: to help those students in brief courses in nursing understand basic concepts of drug therapy . . . to help them realize their responsibility in the administration of medications and appreciate the necessary limitations placed upon them in this function.

There is divergence of opinion in Canada as to whether or not the practical nurse should administer medications. In Manitoba she is permitted to do so and the presentation of material in basic pharmacology as set forth in this text is in the same sequence that we use in our teaching. In part II — Mathematics of Dosages and Solutions — instruction for calculation of divided dosages and of reduced dosage for children is well presented but is not required or permitted in the Manitoba Practical Nurse curriculum. In Part I an arithmetic review is presented.

It would be very helpful to Canadian practical nurses if Chapter 13 on Drug Standards and Reference Books could include information about Canadian drug publications, standards and legislation.

Generally, this manual is similar to the outline of information and instruction given to practical nursing students in Manitoba. It should prove very useful to nurse educators and all those who are concerned with planning courses of instruction for practical nurses.

Essentials of Psychiatric Nursing by Dorothy Mereness, R.N., Ed. D. and Louis J. Karnosh, B.S., Sc.D., M.D. 312 pages. U.S.A.: The C. V. Mosby Company, St. Louis 3, Mo. Canada: McAinsh and Co. Ltd., 1251 Yonge St., Toronto. Ed. 6, 1962.

Reviewed by V. F. Leclair, Maisonneuve Hospital, Montreal.

This book is well-organized and well written. Since 1940 it has gone through six editions, a fact that speaks for itself.

There are three units containing 3-10 chapters each. *Unit I* is devoted to the nurse and her role. *Unit II* focuses attention upon understanding patients; *Unit III* deals with some general aspects of psychiatry. The appendix includes a glossary; a chart of tranquilizers and antidepressants; the classification of mental illnesses as prepared by the American Psychiatric Association. At the end of each chapter there is a summary of the important concepts presented and a list of supplemental references for students.

As the authors state: "The textbook has been written to help the student to understand and function effectively in the therapeutic role of the psychiatric nurse." Thus, Unit I emphasizes the importance for the nurse to understand herself first of all; shows how to develop communication skills; demonstrates how the nurse may use herself as a therapeutic tool. For example: "How to terminate a nurse-patient relationship" is of real interest for the student.

The portion of chapter 8 concerning medication and dosage is outdated and there is insufficient discussion of nursing aspects. Chapter 9 "Improving Nursing Care for the Physically Ill" should be read by every nurse. She would find hints concerning how she can help her physically ill patients and she might become interested in reading the remainder of the book, from which she would gain valuable knowledge.

Unit II reviews, in detail, different behavior in people and shows how important it is for the nurse to understand her

patients. Nursing points are illustrated, most of the time, by case reports. The chapter on rehabilitation of the psychiatric patient shows the importance of the social aspect as part of complete treatment in any mental disease. There is mention of modern planning and its role in today's society; however a few aspects are typically American possibilities.

The last unit deals first, with psychosomatic medicine. It should be of some help to the nurse working in the psychiatric unit of a general hospital. Psychiatry in the law as it is seen in the U.S.A., may interest us because of our own projected changes in relation to commitment. It was quite a good idea to conclude with a chapter on mental hygiene.

The references are numerous, but I wish that American authors would pay a little more attention to European publications, perhaps by mentioning articles written in English reviews or books published in other countries.

Centenary of Nurse Training in Australia. 57 pages. The Royal Women's Hospital, Melbourne, 1962.

This booklet was written to mark the centenary of formal nurse training in Australia. It is meant as a tribute to those who began nurse training at The Royal Women's Hospital, Melbourne, and to those who in the past century have carried forward the ideals of the pioneers.

Pharmacology in Nursing by Elsie E. Krug, R.N., M.A. 825 pages. The C.V. Mosby Company, St. Louis, Mo. Ed. 9. 1963.

Reviewed by Georgette Desjean, professor of nursing, Institut Marguerite d'Youville, Montreal.

The success achieved by previous editions of this text prompted the author to revise and improve it once more. Obviously she is richly experienced and a specialist in nursing education as well as a proficient writer.

The recent appearance of this volume is a measure of the abundance of scientific and educational information related to the application of pharmacology in nursing. The author's aim, as stated in the preface, is to familiarize student nurses with pharmacotherapy and to provide a guide for them for nursing care in this area.

The table of contents provides a clear overview although inequalities in the length of chapters may worry students wishing to study certain aspects at greater length. A complete review of tables of weights and measures necessary to the study of pharmacology is presented at the beginning. In succeeding chapters, pharmacological detail is closely integrated with basic nursing sciences — anatomy, physiology, chemistry, etc. Each medication is discussed in relation to its action, source, classification, use, method of preparation, dosage and method of administration. Contraindications to use are also given. This information is extremely valuable to nurses in their observation of patients. Illustrative material complements explanations. Each chapter concludes with a questionnaire that would be useful for study and review purposes.

A pharmacological glossary and a suggested bibliography for further study round out the text. The author would seem to have achieved her aim; her book represents a worthwhile contribution to nursing and can be admired as much for its artistic presentation of material as for its scientific content. Its use as a reference text for any nurse is advocated.

Diets are for People by Caroline Wood Shearman. 126 pages. Appleton-Century-Crofts, New York. 1963.

Reviewed by Mrs. Vera Moroz, Teaching Dietitian, University of Saskatchewan, School of Nursing, Saskatoon.

The author intended this book primarily for the student of diet therapy — specifically the student nurse and dietetic interne. It would also be useful for the graduate nurse or dietitian as a quick refresher reference.

Essentially concerned with the welfare of the patient, the author has centred all of her writing around him and his problems. The book begins by having the reader take a good look at *why* people eat, and how this may affect the patient's behavior in hospital. In the discussion of disease and diet, the purposes of diet and the problems in following it are stressed. Foods to be avoided or allowed are mentioned generally, rather than specifically, and the reader is directed to the diet manual of her own hospital for actual lists of foods. The most commonly used diets are discussed. The book concludes by giving us a few hints as to how to help people to carry out a diet.

The patient-centred approach shows us that diets are not always easy to follow and if we are aware of problems a patient may have, we are in a better position to

help him to observe his diet. This book would be useful as supplemental reading in a diet therapy course.

Textbook of Obstetrics and Obstetric Nursing by Mae M. Bookmiller, R.N., and George L. Bowen, A.B., M.D., W. B. Saunders Co., Philadelphia. Ed. 4. 1963.

The authors state that this revised edition is "a practical teaching device and not a reference book."

Physical and emotional problems encountered by the patient throughout her pregnancy are well presented. New topics added to this edition include: heart disease, diabetes, mental hygiene, the vacuum extractor, the grand multipara, the Apgar score, the Rh factor, etc. There are now over 100 original illustrations by Dr. Frank Netter, making this one of the most elegantly illustrated textbooks in nursing education. Questions at the ends of chapters have been revised and expanded.

An excellent text for student or graduate nurse.

Textbook of Anatomy and Physiology by Catherine Parker Anthony. 621 pages. The C. V. Mosby Company, Saint Louis. Ed. 6. 1963.

The main objective of this edition remains unchanged — "to present basic facts and principles of body structure and function in a way that makes the teaching of them less laborious, the learning of them less difficult, and both the teaching and learning more exhilarating and more enjoyable."

Content has been revised and brought up to date in sections concerning the cell, hypothalamus, autonomic nervous system, blood clotting, liver functions, pituitary and adrenal hormones and kidney functions. A new Trans-Vision insert of human anatomy has been included. Outline summaries, review questions and summarizing charts and tables have been retained in this new edition.

This text will be appreciated by the student nurse since it is written in a concise manner, while at the same time maintaining its scientific approach. Diagrams throughout are excellent and are clearly labelled.

The quality of content and style found in previous editions of this text have been retained in this sixth edition.

Personal and Community Health by C. E.

Turner, A.M., Ed. M., D.Sc., D.P.H. 415 pages. The C. V. Mosby Company, St. Louis, Mo. Ed. 12, 1963.

Reviewed by Sister Colette Tardif, Institut Marguerite d'Youville, Montreal.

The fact that this text is now appearing in its 12th edition is proof of its value. The present revision gives the author, who is chief of health education with WHO, the opportunity to present interesting and very up-to-date views concerning personal and public health. Drawing upon his extensive experience in this field, the writer directs the attention of the lay reader to the value of health, both from the individual and the social point of view, and stimulates him to develop the habits required to achieve the state of equilibrium and well-being that is health.

The book was designed to meet the needs of various categories of American students at the college level. Since health teaching is included as a part of their educational programs, the material is presented in such a way as to facilitate study. A series of questions at the end of each chapter serve to direct discussions. A list of references on the specific topic under discussion is useful for further study purposes.

In regard to personal health, the wealth of information concerning anatomy, physiology and pathology contrasts with the limited presentation accorded rules of healthful living. Considering the growing importance of psychosomatic medicine, the skimpy discussion of it is regrettable. For Canadian readers, the details of the organization of public health services in the United States will be of minor interest.

Inevitably the nurse will find that there is repetition of information acquired in her professional course of study but, nevertheless, the text has value for her in its presentation of fundamental ideas in health, and in helping her to evaluate programs for student nurses, high school students and industrial workers.

Psychology As Applied to Nursing by Andrew McGhie, M.A., Ph.D. 320 pages. E. & S. Livingstone Ltd., Edinburgh and London. Ed. 3, 1963.

This book has been written primarily for student nurses. In this edition the author has added material concerning psychological disorders that may occur in certain age groups. A new section dealing with psychological tests has been included.

It is surprising to note that the chapter concerning heredity and environment omits any mention or explanation of the major principles of hereditary transmission. Information concerning physiological and social motives — found in most American textbooks of psychology — is not included in this text.

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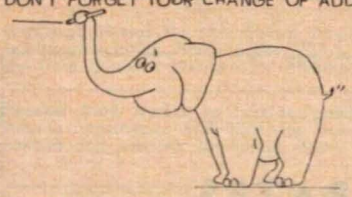

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Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, ear, eye, nose and throat and orthopedic surgery. Good salary and personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario. 7-73-10A

Public Health Nurses (Qualified) for generalized program, by Stormont, Dundas and Glengarry Health Unit located in the Seaway Valley area. Minimum salary $4,000. Annual increment. Allowance for experience. 5-day wk. Employer-shared (50-50) group insurance, portable OMERS pension plan, Ontario Hospital Insurance and P.S.I. coverage (medical, surgical and obstetrical plan). 3-wk. vacation, cumulative sick leave credits, one-half paid as bonus upon leaving after 3-yr. service. Generous car allowance. Reply in writing to: Dr. John A. Thomson, Medical Officer of Health, Box 1058, Cornwall, Ontario. 7-34-5

Public Health Nurses (Qualified). Salary range $3.850 - $4,600, required in a generalized program in rural and semi-urban area adjacent to Metropolitan Toronto. Excellent working conditions including pension plan, group insurance, and transportation arrangements. Write: Dr. R. M. King, York County Health Unit, 64 Bayview Avenue, Newmarket, Ontario. 7-84-2

Public Health Nurse for Dufferin County Health Unit. Annual increment, fringe benefits in effect, generalized program. Apply to: Mr. W. H. Hunter, Secretary, Dufferin County Board of Health, Orangeville, Ontario. 7-90-1

PUBLIC HEALTH NURSE REQUIRED FOR NIPIGON-RED ROCK AREA. Applicant must be registered in Ontario and hold a certificate in Public Health Nursing. Attractive salary schedule. Car will be supplied. Numerous benefits. Apply in writing to: Dr. W. C. MacPherson, Director, Port Arthur and District Health Unit, 93 Balsam Street, Port Arthur, Ontario. 7-106-3

STAFF NURSES and O.R. and OBSTETRIC NURSES for 220-bed accredited hospital with School of Nursing. 1963 salary scale $305-$345. Postgraduate premium $320-$360. Usual personnel benefits, plus proximity to Ottawa, Montreal and Northern New York State. Apply: Acting Director of Nursing Service, Cornwall General Hospital, Cornwall, Ontario. 7-34-1

ONTARIO SOCIETY for CRIPPLED CHILDREN

presents a challenge to Public Health Nurses

Applicants must have at least two years experience in a generalized public health program, preferably in Ontario.

INTERESTING AND CHALLENGING PROFESSIONAL SERVICES INCLUDE:

* rehabilitation of crippled children
* counselling of children and parents
* working with official health agencies

New attractive salary schedule with excellent benefits. Car provided. Pre-service training with salary.

Apply in writing to:

MISS MARGARET MacMILLAN, Reg.N.,
Supervisor, Nursing Service,
350 Rumsey Road,
Toronto 17, Ontario.

Timmy's friends need the help that YOU, as a District Nurse of the Society, could provide.

BERMUDA

Registered Nurses for General Staff. Salary commences at £52.10.0 per mo. Full maintenance in new residence. Transportation allowance. For full particulars, apply: Matron, King Edward VII Memorial Hospital, Bermuda.

QUEBEC

Assistant Head Nurses and Certified Nursing Assistants for 60-bed children's orthopedic hospital. Excellent personnel policies. Apply: Miss Flora M. Lamont, Reg.N., Administrator, Shriners Hospital for Crippled Children, 1529 Cedar Avenue, Montreal 25, Quebec. 9-47-42

REGISTERED NURSE for Laurentian Children's camp, July and August. Excellent conditions and salary. Write: Camp Hagshama, 2025 University Street, Montreal, Quebec. Or phone VI. 4-2831, Local 17. 9-47-58

SASKATCHEWAN

Registered Nurses (3) fo rnew 19-bed hospital, located in Hafford, a growing modern town. Starting salary according to SRNA recommendations, dependent on qualifications and experience. Modern nurses' residence and good personnel policies. Apply to: or Phone on Reverse No. 48 or No. 87 — Director of Nursing, Mrs. Sophie Tkachuk or Secretary Manager, Mr. Eugene Michayluk, Union Hospital, Hafford, Saskatchewan. 10-43-1

Registered Nurses for Nursing Service and Nursing Education, for 150-bed, accredited new hospital, SRNA personnel policies. Apply to: Director of Nursing, Holy Family Hospital, Prince Albert, Saskatchewan. 10-103-1

U.S.A.

Registered Nurses for modern 374-bed General Hospital on the beautiful, warm Peninsula yet only 20-min. from the heart of cosmopolitan San Francisco. Openings in all nursing services including operating room, emergency room, and I.C.U. Excellent personnel policies, many extra benefits and opportunities for advancement. Telephone collect, OXford 7-4061 or write: Director of Personnel, Peninsula Hospital, 1783 El Camino Real, Burlingame, California. 15-5-20

Registered Nurses. Career satisfaction, interest and professional growth unlimited in modern, JCAH accredited 254-bed hospital. Located in one of California's finest areas, recreational, educational and cultural advantages are yours as well as wonderful year-round climate. If this combination is what you're looking for, contact us now! Staff Nurse entrance salary $395 with automatic increase to $455 per mo., supervisory positions at increased rate. Special area and liberal shift differentials paid. Excellent benefits including Blue Cross hospitalization and surgical coverage and liberal personnel policies. Professional staff appointments available in all clinical areas to those eligible for California licensure. Write today: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California. 15-5-12

Registered Nurses for private 258-bed hospital for men, women and children. Staff Nurse salaries from $380-$450, differentials for evenings, nights, communicable disease, operating room and delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave and health insurance. California registration required. Applications and details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California. 15-5-4

Registered Nurses for 233-bed modern hospital. Positions available — all services, no shift rotation. Liberal benefits, advancement opportunities, educational opportunities in area, equal opportunity employer. Apply: Director of Nursing Service, Kaiser Foundation Hospitals, San Francisco 15, California. 15-5-7

Registered Nurses (Ventura County, Southern California, an ideally located, rapidly expanding area has positions open) 350-bed hospital, salary $384-$466, compensation for experience, Nurses' residence, near urban shopping area. Write: Personnel Department, Courthouse, Ventura, California. 15-5-53

REGISTERED NURSES FOR GENERAL DUTY for 98-bed J.A.C.H. accredited hospital with 85-bed Psych. and Convalescent Unit under consideration. Starting salary $395 with $22.50 differential for 3-11 and 11-7 shifts. 40-hr. wk., Good personnel policies, 10 sick days, 7 paid holidays, 2-wk. vacation per year. Resort area near Los Angeles. California registration necessary. Apply: Director of Nursing, Community Hospital, Hawthorne, California. 15-5-54

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Starting salary $375 per mo. plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California. 15-5-39

Registered Nurses, Staff Nurses for permanent positions, various departments, days, eves., nights. Excellent starting salary, increments, benefits and working conditions in one of the largest and finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California. 15-5-3G

General Duty Staff Nurses for 450-bed, fully approved hospital. Salary range per mo: Day Duty, $438-458. P.M. and night duty, $448-468. 40-hr. wk. Paid vacation. 7 paid holidays per yr. Accumulative sick time based on length of service. Liberal hospitalization plan. Nurses' residence. Rooms at reasonable rates. Registration or permit to work in California required. Address applications to: Chief Nurse, Southern Pacific Railroad Hospital, San Francisco, California. 15-5-6B

(a) **Operating Room Nurses** (experienced); basic salary $385 with good financial reimbursement for call. (b) **Obs. Nurses** $385 basic salary with $20 differential for 3-11 or 11-7 shifts. (c) **General Duty Nurses** $375 basic salary, $20 differential for 3-11 or 11-7 shifts. Apply: Director of Nurses, General Hospital, Eureka, California. 15-5-14

THE HAMILTON AND DISTRICT SCHOOL OF NURSING

sponsored by

The Hamilton Health Association

Invites applications for the position of

INSTRUCTOR

QUALIFICATIONS—A University degree and graduate experience in one or more fields of nursing.

Eligibility for Nurse Registration in Ontario.

THE SCHOOL PROGRAM –

CONTROL—The entire curriculum to be planned and controlled by the school to provide an integrated program of instruction and practice.

EXPERIENCE AND PRACTICE—Will be provided in a number of different hospitals and other community health agencies.

LENGTH OF COURSE – 2 YEARS

The first class to be enrolled in the fall of 1964. This is an opportunity for teachers with originality and initiative to work cooperatively in setting up a new program.

For further information write to:

THE DIRECTOR,
Hamilton and District School of Nursing,
Box 590, Hamilton, Ontario.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon and night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California. 15-5-3C

Staff Nurses for 100-bed County Hospital located in the progressive San Joaquin Valley. Salary: $395-$458/m. Starting salary depends on experience. $10 shift differential for evenings and nights. Occasional promotions to Head and Supervising positions. Liberal fringe benefits. Modern nurses' residence at nominal cost. Call or write: Director of Nurses, Tulare County General Hospital, Tulare, California. 15-5-44A

Nurses for new 75-bed General Hospital. Resort area. Ideal climate. On beautiful Pacific ocean. Apply to: Director of Nurses, South Coast Community Hospital, South Laguna, California. 15-5-50

General Duty Nurses for various departments including surgery for 72-bed hospital. Starting salary $375 per mo. with periodic increases and fringe benefits. College town, tourist area, ideal climate. Contact: Superintendent, Alamosa Community Hospital, Alamosa, Colorado. 15-6-1

Executive Director generalized public health nursing agency. Potential for program expansion in rapidly growing community 45 minutes from NYC. Staff 8 full time, 5 relief nurses. **Master's degree, administrative** ability; experience required, salary open. Send résumé to Mr. Charles H. Ulrich, Chairman, Personnel Staff Committee, Visiting Nurse Association, 60 Guernsey Street, Stamford, Connecticut. 15-7-4

General Duty Nurses for 54-bed hospital, minimum starting salary $350 per mo., located near Miami and West Palm Beach. Apply: Director of Nurses, Belle Glade Memorial, Belle Glade, Florida. 15-10-3

REGISTERED NURSES: for 75-bed air-conditioned hospital, growing community. Starting salary $330-$365/m, fringe benefits, vacation, sick leave, holidays, life insurance, hospitalization, 1 meal furnished. Write: Administrator, Hendry General Hospital, Clewiston, Florida. 15-10-1

GENERAL STAFF NURSES for 425-bed private, General Hospital with completely modern facilities. Located in pleasant residential area near the Northwestern University campus and transportation to Chicago loop. Hiring range $5,040 to $5,400 for permanent personnel. Progressive personnel policies. Apply: Director of Nursing Service, Evanston Hospital, 2650 Ridge Avenue, Evanston, Illinois. 15-14-2

Staff Nurses (All Areas) Orientation and staff development programs, "nurse-saving" equipment, challenging working environment, individualized living accommodations in new air-conditioned cottages. Opportunity to participate in nursing practice of the finest quality in our 200-bed General Hospital, located along Lake Michigan shoreline, 30 mi. from Chicago. Starting salaries $390-$410 plus $30 differential for 3-11 and 11-7. Write: Director of Nursing, Highland Park Hospital, Highland Park, Illinois, for detailed brochure. 15-14-3

Staff Nurses and Licensed Practical Nurses (Openings in several areas, all shifts). Minimum starting pay $77 R.N.'s; L.P.N.'s $61 per wk., experience considered, differentials paid for reliefs, nights. Every other weekend off in small community hospital 2 miles from Boston. Living quarters available. Contact: Miss Elizabeth B. Kennedy, R.N., Director of Nursing, Chelsea Memorial Hospital, Chelsea, Mass. 15-22-1

Staff Nurses 380-bed hosp. new 120 med.-surg. unit. Trans. pd. 1st class air to Albuq. and return within U.S. in exchange for 1-yr emp. contract. Come to New Mexico "Land of Enchantment." Career opportunities, largest pvt. JCAH accredited hosp. in state; near U. of New Mexico, R.N. & B.S. pgm. Practical Nurse pgm. accredited state & NAPNE. Vacancies, Med-Surg. & occasionally O.B., Peds., & O.R., salaries $315 per mo. even., night or O.R. with call; 6-mo. increases up to $375; days $300 per mo. with increases up to $360. Rotation from day duty is required only when no person desiring permanent P.M. of night tour is available. Liberal personnel policies include: optional Blue Cross, Discount Hosp. Services, pd. sick leave cumulative to 5 wks., annual physical exam., vacation 1 yr. — 2 wks., 2 yrs. — 3 wks., 5 yrs. — 4 wks. Active in-service pgm. Occasional vacancy hosp. owned apts. New Mexico licensure as professional nurse & U.S. Citizenship (or Immigration Visa) required. Write or call collect: Mrs. Emily J. Tuttle, Dir. of Nursing, Presbyterian Hospital Center, 1012 Gold, S.E., Albuquerque, New Mexico. Phone 243-5611. 15-32-3

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric and pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th Street, Cleveland 6, Ohio. 15-36-1D

Staff Nurses for modern 400-bed tuberculosis hospital, suburban Cleveland, Ohio. Monthly salaries start at $396 with semi-annual increments. Extra for night and relief duty, 5-day work wk., 3-wk. paid vacation, 6 paid holidays, liberal sick leave, comfortable accommodations in nurses' residence at low rate. Learn and earn at a progressive accredited hospital in a growing community. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio. 15-36-1E

Registered Nurse (Scenic Oregon, vacation playground, skiing, swimming, boating and cultural events) for 295 bed teaching unit on campus of University of Oregon medical school. Salary starts at $387. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon. 15-38-1

Clinical Instructors (2) Fundamentals of Nursing and Obstetrical Nursing. 20 students enrolled annually. Bachelor's degree required, Master's preferred. Salary $450, or better, depending upon qualifications. Good personnel policies. Write to: Director of School of Nursing, Methodist Hospital, Mitchell, South Dakota. 15-41-1

PUBLIC HEALTH STAFF NURSE, University Community and Recreational area. Salary based on preparation and experience. Write: Director, Visiting Nurse Association, 258 Pearl Street, Burlington, Vermont. 15-46-2

Staff Nurses — University Hospital wants you if you want a challenging and rewarding position in a modern expanding 320-bed teaching and research hospital located on campus. Salary $380-$442/m. Opportunities in clinical research, premature center, open heart surgery, physical medicine, in addition to the general services. Liberal benefits including tuition free courses after six months. Contact: Director of Nursing Services, University Hospital, 1959 Pacific Avenue, Seattle, Washington. 15-48-2D

ASSISTANT DIRECTOR OF NURSING

Required for

ROYAL OTTAWA SANATORIUM

WHICH HAS A NEW PSYCHIATRIC UNIT

Apply to:

DIRECTOR OF NURSING,

Royal Ottawa Sanatorium, Ottawa, Ontario.

GRADUATE STAFF NURSES

required for

MEDICAL AND SURGICAL AREAS

University teaching hospital. Applicants should be eligible for Ontario Registration. Personnel policies and further information may be obtained from:

DIRECTOR OF NURSING,

Kingston General Hospital, Kingston, Ontario.

PUBLIC HEALTH NURSES

REQUIRED FOR HEALTH BRANCH, B.C. CIVIL SERVICE

Positions available for qualified Public Health Nurses in various centres in British Columbia. SALARY: $375 - $462 per month; car provided. An opportunity for interesting and challenging professional service in this beautiful and fast-developing Province. For further information and application forms, apply to The Director, Public Health Nursing, Department of Health Services and Hospital Insurance, Parliament Buildings, Victoria, B.C., or to The Chairman, B.C. Civil Service Commission, 544 Michigan Street, Victoria, B.C. COMPETITION No. 64:1

ASSISTANT DIRECTOR OF NURSING SERVICE

Wanted for McKellar General Hospital. An active treatment hospital of 380 beds, with a progressive school of nursing. Postgraduate preparation essential; Baccalaureate Degree preferred.

APPLY TO:

Director of Nursing,
McKELLAR GENERAL HOSPITAL,
Fort William, Ontario

REGISTERED NURSES REQUIRED

For General Duty in modern 18-bed private Hospital in Iron mining town, 140 miles north of Sault Ste. Marie, Ontario.

SALARY RANGE $320 MINIMUM TO $360 MAXIMUM

Allowance for experience. Board and room available at $20 per month. Transportation allowance up to $50 after 6 months.

Apply:

SUPERINTENDENT OF NURSES, LADY DUNN HOSPITAL, WAWA, ONTARIO.

ASSOCIATE DIRECTOR OF NURSING (IMMEDIATELY). Salary range $6,432-$8,400, depending upon experience. Master's Degree required. Assists with the administration of all functions of the Department of Nursing in a large general teaching hospital center (approximately 1,300 beds) which includes: two general hospitals, a rehabilitation hospital, a sanatorium section and outpatient clinic. Directly responsible for the administration of nursing service in one of the general hospitals (approximately 500 beds) and the rehabilitation hospital (approximately 100 beds); Consults and plans with the director of the department of nursing in the administration of nursing service for the entire department of nursing in the hospital division and relieves the director when necessary. Liberal benefits. Apply: Post Office Box 67, Medical College of Virginia, 12th and Broad Streets, Richmond 19, Virginia. 15-47-2

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at Ohio's LARGEST Tuberculosis Hospital Offers...

- Immediate openings for Registered Nurses.
- Available living quarters with full maintenance—estate style living—convenient transportation.
- 3 weeks vacation with full pay—holidays—sick leave cumulative to 90 days—survival and disability protection—refundable pension plan.
- Staff Nurses—$396 to $473 monthly.
- Inservice education—expanding program.

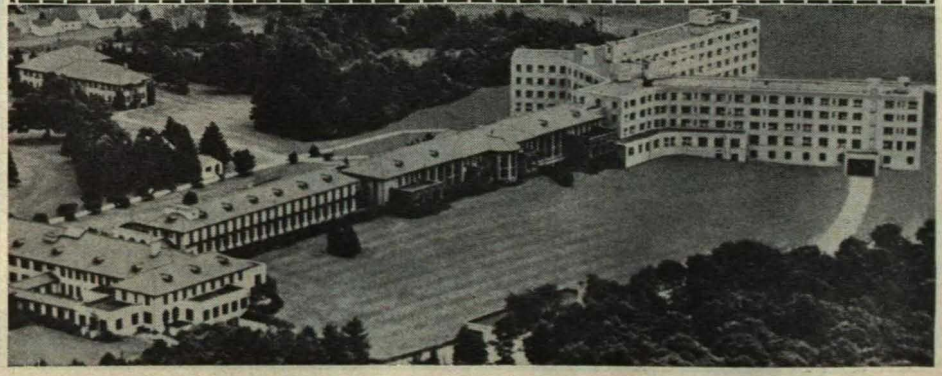
FOR MORE DETAILS, CLIP AND MAIL TODAY TO:

Director of Nursing—Sunny Acres Cuyahoga County Tuberculosis Hospital
4310 Richmond Road – Cleveland, Ohio 44122

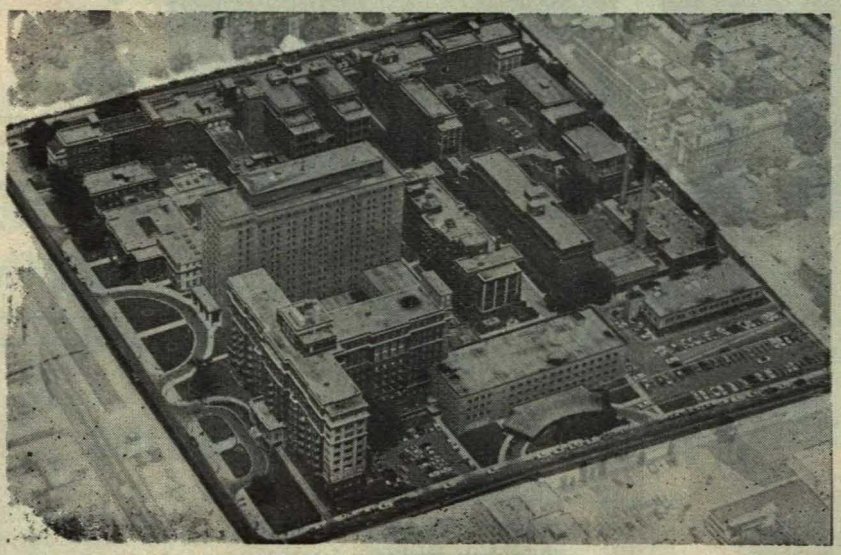
NAME_____

ADDRESS_____

CITY_____ PROVINCE _____



TORONTO GENERAL HOSPITAL



NURSING OPPORTUNITIES
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REGISTERED NURSES AND CERTIFIED NURSING ASSISTANTS

Planned Orientation Programme — Inservice Educational Programmes
Opportunity to gain additional knowledge in specialized fields of nursing
Excellent personnel policies
Salaries commensurate with prevailing current salaries in Metropolitan Toronto

For information or application write to:
DIRECTOR OF NURSING, TORONTO GENERAL HOSPITAL,
101 College Street, Toronto 2, Ontario.

THE COLLINGWOOD GENERAL AND MARINE HOSPITAL

Invites applications for

Registered Nurse for Night Supervisor
Central Supply Room Supervisor
Pediatric Ward Head Nurse

Registered Nurses and Registered Nurse Assistants for General Duty in this modern 126-bed hospital. We have recently completed our new extension and require additional staff. Opportunities in all departments. The Town of Collingwood on beautiful Georgian Bay offers the finest in winter and summer sports.

For further particulars write:
DIRECTOR OF NURSING SERVICES,
Collingwood General and Marine Hospital,
Collingwood, Ontario.

U.S.A.

New York Polyclinic Medical School and Hospital in heart of Manhattan. Six month courses for qualified registered nurses in Operating Room Nursing, and Medical Surgical-Out Patient Department Nursing. Classes begin in March and September, include 220 hours of instruction and supervised clinical experience. Room, meals, medical care, and monthly cash stipend. For information write: Director of Nursing Education, 345 West 50th Street, New York, New York 10019. 15-33-24

GENERAL DUTY NURSES FOR ALL DEPARTMENTS

Gross salary for nurses registered in the Province of Ontario $335 monthly with annual increment $10 monthly to $385.

Salary until registration is established — $305 monthly.

Rotating periods of duty — 40 hour week, 8 statutory holidays annually — Annual vacation 21 days.

Annual sick time 12 days after one year, unused portion cumulative to 36 days.

Hospitals of Ontario Pension Plan.

Ontario Hospital Insurance and Physicians' Services Incorporated, 50% payment by hospital.

Apply:

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO

DIRECTOR OF NURSING

FOR UNIVERSITY HOSPITAL, SASKATOON, SASKATCHEWAN

This position carries full responsibility and authority for nursing service in a 560-bed teaching, base hospital situated on the campus of the University of Saskatchewan.

Applicants should preferably hold a degree in Nursing and have considerable administrative experience in the field of Nursing Service. This appointment offers a challenging opportunity to participate in planning further development in inservice education, progressive patient care, the addition of a large service wing and in the extension of rehabilitative and psychiatric facilities. Excellent salary, pension plan, group insurance, sick leave, vacation and travel policies in effect.

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Executive Director,
UNIVERSITY HOSPITAL, SASKATOON, SASKATCHEWAN.

GUELPH GENERAL HOSPITAL

Active — 200 Beds — Fully Accredited

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FOR SEPTEMBER 1964:

OPERATING ROOM SUPERVISOR

INSTRUCTOR FOR OPERATING ROOM

SCIENCE INSTRUCTOR

GENERAL STAFF NURSES

REGISTERED NURSING ASSISTANTS

Pleasant City of 38,000. One hour from Toronto via 401. Good Personnel Policies.

For further details apply to:

THE DIRECTOR OF NURSING,
General Hospital,
Guelph, Ontario.

PORT COLBORNE GENERAL HOSPITAL

PORT COLBORNE, ONTARIO.

requires

REGISTERED NURSES

For recently expanded General Hospital of 166 beds within easy driving distance of American and Canadian metropolitan centres. Salary $335 per month with five annual increments of $120 per year. Consideration given for previous experience obtained in Canada. Vacancies in all departments.

Apply:

DIRECTOR OF NURSING,
General Hospital,
Port Colborne, Ontario.

OPERATING ROOM SUPERVISOR

for

650-bed active hospital and school of nursing.

Operating Room services include cardio-vascular, neurosurgery, genito-urinary, ear, eye, nose and throat and orthopedic surgery.

Salary is commensurate with qualifications and experience. Good personnel policies.

For further information apply to:

Director of Nursing,
HAMILTON GENERAL HOSPITAL,
Barton Street East, Hamilton, Ontario.

Have You Considered Nursing in New England?

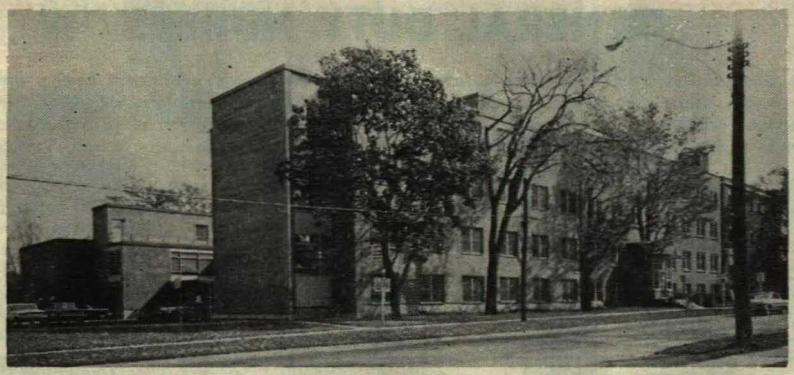
- Suburban living within 15 minutes of Boston.
- Handy year-round recreation — ski areas and beautiful beaches 1½h. away.
- Educational and cultural advantages of 8 universities.

Will You Consider
LAWRENCE MEMORIAL?

- Well-staffed nursing service.
- Opportunities for rapid advancement.
- Liberal personnel policies.

For information write:

Personnel Director,
LAWRENCE MEMORIAL HOSPITAL,
170 Governor's Avenue,
Medford 55, Massachusetts.



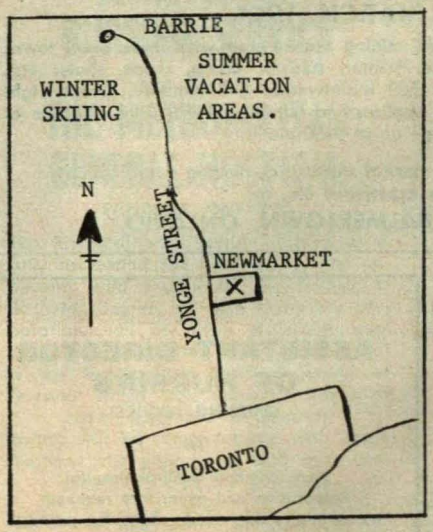
ASSISTANT DIRECTOR OF NURSING (EDUCATION)

Required for 75-student School of Nursing in this 250-bed accredited hospital in the Seaway Valley. University preparation required. Good personnel policies including four weeks' vacation, nine statutory holidays, pension plan, group insurance, etc.

Apply to:

ADMINISTRATOR,
CORNWALL GENERAL HOSPITAL, CORNWALL, ONTARIO.

YORK COUNTY HOSPITAL



ONE HOUR FROM DOWNTOWN TORONTO

260 bed Hospital with new facilities including:

INTENSIVE CARE UNIT
SELF CARE UNIT
PSYCHIATRIC UNIT

REGISTERED NURSES: $335-$400 per month.

REGISTERED NURSING ASSISTANTS: $230-$265 per month.

LIBERAL PERSONNEL BENEFITS INCLUDE:

Pension Plan, Group Life Insurance,
Medical and Hospital Insurance.
Residence accommodation available.

Please write for further details concerning employment opportunities to:

DIRECTOR OF NURSING, YORK COUNTY HOSPITAL,
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GENERAL DUTY NURSES

Two General Duty Nurses, starting salary $332 - with two years' experience $349 - with four years' experience $366. Travelling expenses paid on completion of one year's service. Personnel policies as in accordance with provincial agreement. Health plan and retirement plan in operation. Comfortable nurses' residence. Situated 80 miles upcoast from Vancouver with daily bus and plane connections.

Apply to:

Director of Nursing,
POWELL RIVER GENERAL HOSPITAL,
Powell River, British Columbia.

ASSOCIATE DIRECTOR OF NURSING EDUCATION

Required for three year diploma School of Nursing associated with a modern 163-bed General Hospital. Present enrollment of 60 students with view to increasing enrollment to 90 students. Construction of new School and Residence to commence in 1964. Postgraduate preparation essential, Baccalaureate Degree preferred. Salary commensurate with experience and preparation.

Apply to:

Director of Nursing,
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THE MARGARET COCHENOUR MEMORIAL HOSPITAL

COCHENOUR, ONTARIO

Invites applications for the position of

MATRON, FOR MARCH, 1964

28 bed active General Hospital located in gold mining tourist area with three small towns close by. Accessible by road, bus and plane. Winter, summer sports, shops, shows etc., available in area. Private suite in residence. Full maintenance $45 monthly. Twenty-eight days vacation after each year's employment. Applicant to handle general administration of the hospital. Salary range up to $450 monthly.

Please forward full information as to age, marital status etc., nursing qualifications, registration, previous experience etc. to:

MR. W. R. B. TROW, AT BALMERTOWN, ONTARIO.

GENERAL STAFF NURSES

SALARY $380 to $425

(Commensurate w/experience)

$3.00 per day differential for evenings. $1.50 differential for nights. Positions available in Birthroom, Post Partum, Newborn Nursery and Medical - Surgical areas. Time and a half for overtime. Quarters available on hospital grounds. Other liberal fringe benefits.

For more information write:

Personnel Director,
WOMAN'S HOSPITAL,
432 E. Hancock, Detroit 1, Michigan.
TEmple 3-2000

ASSISTANT DIRECTOR OF NURSING

(NURSING SERVICE)

for

New 220 bed General Hospital.
Preparation and experience required.

For further information apply to:

Director of Nursing,
BRANDON GENERAL HOSPITAL,
Brandon, Manitoba.

ASSOCIATE DIRECTOR OF NURSING SERVICE

General Hospital of 280 beds located in a progressive and friendly city in sunny southern Alberta. Population 27,000. School of Nursing with a maximum enrollment of 90 Students. Excellent personnel policies including coverage for hospitalization, medical services and a pension plan. Salary based on education and experience.

Write to:

Director of Nursing,
MEDICINE HAT GENERAL HOSPITAL,
Medicine Hat, Alberta.

NOTRE DAME HOSPITAL

North Battleford, Saskatchewan

REQUIRES

General Staff Nurses and Certified Nursing Assistants for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary range: R.N. $300 to $375, C.N.A. $205 to $235 gross per month. Differential for evening and night duty for R.N.'s. Accommodation close to hospital if desired

Apply to:

DIRECTOR OF NURSING SERVICE,
Notre Dame Hospital, North Battleford, Sask.

ASSISTANT DIRECTOR OF NURSING SERVICE

FOR UNIVERSITY HOSPITAL, SASKATOON, SASKATCHEWAN

Applications are invited for appointment to the position of a senior assistant director of nursing in a 560-bed teaching hospital on the campus of the University of Saskatchewan. The position carries responsibilities for co-ordinating nursing care activities and for assuming the duties of the Director of Nursing Service in her absence. This challenging appointment provides an opportunity to assist in planning progressive patient care and the development of nursing services in a major expansion program.

Applicants preferably should hold a degree in nursing and have at least four years' experience in supervision or instruction of nursing service.

Excellent salary, pension plan, group insurance, sick leave, vacation leave in effect.

Please address applications or requests for additional information to:

Dr. A. L. Swanson, Executive Director,
UNIVERSITY HOSPITAL, SASKATOON, SASKATCHEWAN.

VICTORIA HOSPITAL

London, Ontario

HEAD NURSE for fifty-bed (50) Psychiatric Unit. Duties to commence immediately. Diploma in Nursing Service Administration and postgraduate experience in psychiatric nursing preferred. Salary commensurate with qualifications and experience.

Apply:

DIRECTOR OF NURSING
Victoria Hospital, London, Ontario

OSHAWA GENERAL HOSPITAL

Oshawa, Ontario

Requires for School of Nursing

CLINICAL INSTRUCTOR IN SURGICAL NURSING

with Certificate in Nursing Education

For further information, apply to:

DIRECTOR OF NURSING,
Oshawa General Hospital, Oshawa, Ontario.

GENERAL DUTY NURSES

SALARY RANGE $327 - $362

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Responsible for In-service program for Non-Professional Staff.

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for

SCIENCE
SURGICAL-CLINICAL

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SCHOOL OF NURSING

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GRADUATE COURSE

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Approved Students enter under Visitors Exchange

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